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Individual #25 was not observed to participate in skill-building activity during the observation.

During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated if Individual #25 was sitting in his recliner with his head down, he was probably asleep. The QMRP stated staff were to follow the scenario books and activity schedules.

5. Individual #23's PCP, dated 12/7/05, documented a 56 year old male diagnosed with severe mental retardation, organic mood disorder, organic anxiety disorder, and seizure disorder.

a. During an observation on 5/19/06 from 4:00 - 6:10 p.m. (2 hours 10 minutes), Individual #23 was noted to be engaged in the following activities:
4:00 - 4:13 p.m.: He sat in a chair at a dining table. He was noted to periodically have his left thumb in his mouth.
4:13 - 4:15 p.m.: He stood and wandered around the room, then returned to the chair and sat down.
4:15 - 4:50 p.m.: A staff turned on music and he wandered around the living area. Occasionally, he sat cross-legged in a recliner and rocked back and forth. He was noted to periodically have his left thumb in his mouth. At 4:44 p.m., a staff person talked to him for no more than thirty seconds and then walked away. He continued to sit cross-legged in the recliner and periodically put his left thumb in his mouth.
4:50 - 5:26 p.m.: He sat at the dining table. He was noted to scream occasionally and periodically, he had his left thumb in his mouth.

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5:26 - 5:30 p.m.: He was given a glass of juice.
5:30 - 5:35 p.m.: He washed his hands with staff assistance and returned to the dining table and sat down.
5:35 - 6:05 p.m.: He ate dinner. Periodically, he ate food with his fingers and staff were not noted to prompt him to use his utensils or intervene.
6:05 - 6:10 p.m.: He was presented with a second tray of food. He stood and took the surveyor by the hand towards his bedroom. The surveyor asked a nearby staff to assist him and the staff person accompanied him to his restroom. At 6:07 p.m., he came out of his bedroom and sat in a recliner in the living area. He remained there until the observation ended at 6:10 p.m.

With the exception of eating, Individual #23 was engaged in skill building activity for no more than 7 minutes during the observation.

b. During an observation on 5/20/06 from 1:30 - 2:30 p.m. (1 hour), Individual #23 was noted to be engaged in the following activities:
1:30 - 1:35 p.m.: He was standing in the hallway watching others.
1:35 - 1:45 p.m.: He sat cross-legged in a recliner in the living area.
1:45 - 1:55 p.m.: He was standing in the hallway screaming and staff adjusted his shorts. He then went and sat in the recliner in the living area. Periodically, he rocked back and forth in the recliner and had his left thumb in his mouth.
1:55 - 2:03 p.m.: He went for a walk within the unit with a staff person.
2:03 - 2:30 p.m.: He returned from his walk and sat in the recliner in the living area. Periodically, he rocked back and forth in the recliner and had

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his left thumb in his mouth. At 2:21 p.m., a staff talked with him for approximately 10 seconds and left the area. He remained in his recliner and periodically, rocked back and forth in the recliner and put his left thumb in his mouth when the observation ended.

Individual #23 was engaged in skill building activity for no more than 8 minutes during the observation.

During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated staff were to follow the scenario books and activity schedules.

6. Individual #24's PCP, dated 1/25/06, documented a 58 year old male diagnosed with severe mental retardation, seizure disorder, and spastic quadriplegia. He used a wheelchair for ambulation and mobility.

a. During an observation on 5/19/06 from 4:00 - 6:10 p.m. (2 hours 10 minutes), Individual #24 was noted to be engaged in the following activities:
4:00 - 4:05 p.m.: He was sitting in his wheelchair and the front of his shirt was wet. When asked, present staff stated it was from his drooling.
4:05 - 4:08 p.m.: A staff person informed him that they should change his shirt. He put the wet area of the shirt in his mouth and propelled himself down the hall, away from the staff.
4:08 - 4:15 p.m.: He was assisted to go to his bedroom and changed his shirt. He came out of his bedroom at 4:13 p.m., and a staff person wheeled him to the outside patio.
4:15 - 4:40 p.m.: He propelled himself around the patio area.

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W 196	Continued From page 93 4:40 - 5:15 p.m.: He propelled himself around the unit and then into his bedroom. 5:15 - 5:19 p.m.: He came out of his bedroom holding a plastic ring. At 5:19 p.m., he was noted to be chewing on a sock. When asked, present staff said it was his sock. With prompting, he released his bite on the sock and staff removed it from his mouth. 5:19 - 5:50 p.m.: He propelled himself around the unit. 5:50 - 6:10 p.m.: He was transferred from his wheelchair to the dining table. Staff used a built-up angled spoon and fed him his dinner meal. Individual #24 was engaged in skill building activity for no more than 5 minutes during the observation. b. During an observation on 5/20/06 from 1:30 - 2:30 p.m. (1 hour), Individual #24 was noted to be engaged in the following activities: 1:30 - 1:55 p.m.: He was eating lunch with physical assistance from staff. 1:55 - 2:18 p.m.: He propelled himself around the unit, and at 1:57 p.m., he went to his bedroom and closed the door. 2:18 - 2:30 p.m.: A staff person walked into and out of his bedroom. He remained in his room with the door closed when the observation ended. With the exception of eating, Individual #24 was not engaged in skill building activity during the observation. During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated staff were not to feed Individual #24 and staff were to follow the	W 196		

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W 196	Continued From page 94 scenario books and activity schedules. 7. Refer to W249 as it relates to the facility's failure to ensure individuals received training and services consistent with their PCPs. 8. Refer to W250 as it relates to the facility's failure to ensure active treatment schedules were sufficiently developed to direct the staff.	W 196		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure behavioral assessments were current, comprehensive, and accurately identified the individuals' behavioral status and needs for 6 of 21 individuals (Individuals #13 - #16 and #18) whose behavior management plans were reviewed. This resulted in a lack of information on which to base program objectives and interventions. Findings include: 1. On 5/15/06, the Clinical Director provided a memo related to Pine Group 1. The memo stated the following had occurred: 8/05: The QMRP was on leave until she resigned on 11/2/05 and other professional staff were assisting to perform the QMRP responsibilities until a new QMRP was hired on 1/27/06.	W 214		

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W 214	Continued From page 95 11/05: The adolescents were combined into one group. "The move of course did cause increased problems." 12/2/05: The Pine Group 1 Clinician resigned. The Clinical Supervisor was assigned as the interim Clinician until a new Clinician could be hired on 3/6/06. Additionally, the individuals residing on the unit changed as some were discharged and some were admitted (i.e., Individuals #5 and #12 were admitted on 10/21/05 and 2/3/06 respectively), increasing the number of maladaptive behaviors and restraints on the unit. Individual #15's BSP, dated 1/27/06, stated he was a 14 year old male with diagnoses which included bipolar disorder, hypomania vs. mixed with psychosis, ADHD combined type, oppositional defiant disorder by history, learning disability not currently specified, nocturnal enuresis, and probably mild mental retardation. The BSP included objectives for assaults, DOP, LWOP, and bizarre speech. The "Functional Assessment" section of the plan stated he was "very sensitive to noise and chaos which can result in his becoming nervous, frustrated or anxious which leads to yelling at others and sometimes escalating into targeted behaviors like physical assault and LWOP." The assessment did not include information related to continuing changes in his peer group, the changes in his treatment team members, or what impacts those changes were having on Individual #15's behavior.	W 214		

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W 214	Continued From page 96 Without updated assessment information in his BSP, reflecting environmental factors which potentially impacted his maladaptive behavior, the facility would not be able to ensure Individual #15's IDT had sufficient assessment information necessary to make fully informed decisions and recommendations regarding his intervention strategies. 2. Individual #14's BSP, dated 3/29/06, stated he was a 14 year old male. His BSP included objectives for assaults, self induced vomiting, destruction of property, and self harm. He required 1:1 staffing. His BSP stated the plan was being revised to "request consent for medication changes. Medication changes are being considered due to the concern over [Individual #14's] increased frequency of self-induced vomiting." His BSP also stated Anafranil would replace Lexapro and Xanax-XR would be started to better address issues of impulse control disorder (not otherwise specified) and Anxiety disorder (not otherwise specified) "as evidenced by assaults, self harm, and episodes of self induced vomiting due to anxiety." The plan further stated "This individual appears to continue to experience difficulty with processing his anxiety which results in increased frequencies of self-induced vomiting..." The "Functional Assessment" section of the plan stated "A major antecedent to [Individual #14's] behaviors, particularly assaults and vomiting, are scheduled and unscheduled visits with his family. [Individual #14] tends to become particularly agitated when he had contact with his biological mother, via telephone, or scheduled or	W 214		

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unscheduled visits. Recently, [Individual #14's] mother had a child. She had visited somewhat regularly prior to the baby's birth. However, the number and length of her visits has decreased and become less predictable, and [Individual #14] appears to be affected by it. He becomes assaultive both prior to and after her visits..." The "Functional Assessment" section in his BSP also stated many of his "assaults appear to be when he is feeling overwhelmed by his environment being too chaotic and/or he is intimidated by something that is going on in his environment, such as another peer being restrained or aggressive..." The assessment did not include information related to continuing changes in his peer group (Individual #12 being admitted on 2/3/06, increasing the number of maladaptive behaviors and restraints on the living unit) or the changes in his treatment team members.

When asked about the functional assessment information included in Individual #14's BSP, the current QMRP stated during an interview on 6/15/06 at 8:56 a.m., his mother had a baby a long time ago, before she came and the QMRP who had assisted on the unit stated he believed the functional assessment was moved as a block from the old document to the new one.

The functional assessment information included in Individual #14's BSP was not updated regarding other factors which potentially impacted his maladaptive behavior.

3. Individual #16's BSP, updated 5/17/06, stated he was a 15 year old male. His BSP included objectives for assault, suicide threats, destruction of property, self injurious behavior, and leaving

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W 214	Continued From page 98 without permission. The plan stated his "behaviors of physical assaults continue, but with variable frequency. Suicide threats have increased significantly since the inception of the last program. Other behaviors of leaving without permission and self harm have also increased. Reports of psychotic behaviors (e.g., bizarre thoughts, auditory hallucinations) continue." a. The BSP stated he "had been on a slow taper off the Risperdal until September when he had an increase in symptoms and the taper was stopped at the current levels. The team will monitor and continue the taper if [Individual #16] is able to tolerate it. The next med to be challenged would be the Topamax." His BSP further stated he "knew he was going to court to discuss possible re-commitment to [the facility] and had hope that he would go home so his behaviors were very good in July and August [2005]. He was recommitted in September and the data reflects his disappointment and frustration." The plan included behavioral data reflective of physical assaults, LWOP, DOP, suicide threats, sexual misconduct, and self harm from 1/05 - 12/05. The plan was not updated to include current data/assessment information and no data/assessment information regarding his "psychotic behaviors (e.g., bizarre thoughts, auditory hallucinations)" was included in the plan. Without sufficient assessment information based on objective current data regarding Individual #16's maladaptive and psychotic behaviors, the facility would not be able to ensure the IDT had adequate information on which to base program recommendations/decisions.	W 214		

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W 214	Continued From page 99 b. His BSP included an objective to "have a T-score of 55 or less on the Conner's' [sic] Rating Scale (ADHD) subcategory tested quarterly for 6 months..." The data collection section of the plan stated the Rating Scale "will be administered every three months" and the Depression Observation Checklist will be administered monthly..." No updated data/assessment information related to ADHD and Depression scales (quarterly score, average score, etc.) was available. Without sufficient assessment information based on objective current data regarding Individual #16's ADHD and Depression ratings, the facility would not be able to ensure the IDT had adequate information on which to base program recommendations/decisions. c. Individual #16's 5/16/06 BSP included a medication plan which stated he received Risperdal 1 mg each morning and 2 mg each evening and Abilify 2.5 mg each morning. However, his PDR notes documented his medications had been changed as follows: - 10/7/05: The PDR notes stated his Risperdal was tapered from 6 mg a day down to 2 mg a day. - 12/16/05: The PDR note included a plan to increase his Abilify from 2.5 mg to 5 mg each morning and consider a further decrease of Risperdal in 3 months. His BSP was not updated to reflect Individual #16's current medication doses. Without updated information related to Individual	W 214		

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#16's behavior modifying medications, the facility would not be able to ensure Individual #16's IDT had accurate assessment information necessary to make fully informed decisions/recommendations regarding his intervention strategies.

4. Individual #13's BSP, updated 6/16/05, stated he was a 16 year old male whose diagnoses included impulse control disorder (not otherwise specified) paraphilias, and mild to moderate mental retardation. His BSP included objectives for physical assaults, sexual misconduct, invasion of space, and grooming related to sexual misconduct. He was re-admitted to the facility on 3/23/05.

a. His BSP stated "This 05-21-05 update is to address [Individual #13's] grooming behaviors as well as staff instructions to assist [Individual #13] in better managing his grooming behaviors. The update on 6/16/05 is to include additional positive interventions such as anger management." The status section of the plan stated his first several weeks at the facility had been "relatively uneventful. Then [Individual #13] began to re-engage in some of his previously documented challenging behaviors to include: attempts to choke staff and assaults toward his peers, and making verbal threats towards staff and peers. Further, [Individual #13] began to display sexual grooming type behaviors and poor physical boundaries with his peers and staff. Based on his history at [the facility] and other community placements the team feels strongly that the low number of his targeted behaviors since admission reflect a 'Honeymoon period'. The treatment team anticipates an increase or reemergence of

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W 214	Continued From page 101 targeted behaviors." Individual #13's status section of his BSP was not updated when the 5/21/05 and 6/16/05 revisions were made to his BSP. Without assessment information regarding his current status, the facility would not be able to ensure the IDT had adequate information on which to base program recommendations/decisions. b. The data for targeted behaviors section of the plan stated "The Treatment Team is still collecting baseline data for [Individual #13's] targeted behaviors as he has only been at [the facility] for approximately one month. Since he arrived he has assaulted staff twice and reported to his counselor that he 'will hurt anyone who makes him mad'. He has also reported to his counselor that he often thinks about certain boys living on his unit in a sexual way and wonders what it would be like to 'have sex with them.' He has told his counselor that he masturbates successfully while thinking about these particular boys. [Individual #13] also reports to his counselor that he wonders what it would be like to have sex with other boys when he is out in the community [sic] On prior occasions, he had assaulted a school aid...which resulted in severe head and neck injuries. He also assaulted his teachers and one was injured. It takes at least 4 people to restrain [Individual #13] due to his strength and the violence of his assaults. Based on the nature of his behaviors warranting readmission and [Individual #13's] historical data, it is believed that the components of this program represent the least restrictive intervention to ensure safety and protect [Individual #13] and others from harm. Below is historical data on	W 214		

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[Individual #13's] targeted challenging behaviors prior to his discharge in 2003." However, the data table in the plan was identified as 2005 data. It was not clear whether the data was reflective of 2003 or 2005 data.

Without sufficient assessment information based on objective current data regarding Individual #13's maladaptive behaviors, the facility would not be able to ensure the IDT had adequate information on which to base program recommendations/decisions.

c. Individual #13's BSP, updated 6/16/05, stated he was receiving Trileptal 1200 mg each day and Seroquel 600 mg each day. However, Individual #13's PDR notes documented his medications had been increased as follows:

10/14/05 - Seroquel was increased to 200 mg each morning and 600 mg each evening, for a total of 800 mg daily and Trileptal was increased to 600 mg each morning and 900 mg each evening, for a total of 1500 mg daily.

Individual #13's medication changes were not reflected in his BSP. Without updated information related to Individual #16's behavior modifying medications, the facility would not be able to ensure Individual #16's IDT had accurate assessment information necessary to make fully informed decisions/recommendations regarding his intervention strategies.

5. Individual #18's PCP, dated 5/11/06, stated he was a 21 year old non-verbal male, diagnosed with severe mental retardation, possible autism, seizure disorder by history, and multiple scars

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secondary to self injurious behavior. Individual #18's PCP contained a "Behavior Support Program," dated 8/30/05, to instruct staff as to how to intervene when he engaged in the self-injurious behavior of hitting his head.

Individual #18's QMRP and Clinician were interviewed on 5/22/06, from 11:10 a.m. - 11:55 a.m. and from 1:35 p.m. - 2:20 p.m. They were asked if staff were to intervene by blocking Individual #18's initial and subsequent hits to his head. They replied no, as doing so would escalate the behavior. Information was requested from the professionals to support that blocking Individual #18's hits to his head was tried systematically and demonstrated to be ineffective. The clinician stated that a functional assessment had been completed which reflected their statement to be correct. The surveyor requested the functional assessment. The Clinician stated he had a summary of the assessment. He provided the surveyor a document titled "Summary of Conditions presented 8/12/04" (from the functional assessment) on 6/12/06. The summary read as follows:

* "In these observations Biting self (SIB), slapping self (SIB) and hits to head (self stim behavior) was recorded. Biting self and slapping self would have been treated as the same but the slapping self did not occur."

* Item #9 followed the above statement. It read - "Task Demand/block---In this condition (Individual #18) was asked to do a task and when he bit/slapped himself the bit/slap was blocked." This statement contradicted the preceding one, as it said he had slapped himself.

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W 214	Continued From page 104 * The graph, contained on page 2 of the document, was labeled "Bites to Self." The first sentence after the graph stated the "graph reflects that (Individual #18) exhibits SIB (bites self) most often when asked to do a task and when the biting self if (sic) blocked the rate of biting self- increases. Leaving (him) alone, or not interacting with him decreases the rate of biting." * The statement which followed the statement above read, the "conclusion to the conditions presented is that SIB (biting/slapping self) is more likely to occur when he is ask (sic) to do a task and Blocking the SIB tends to increase the frequency of the SIB and also increases his attempts to assault Staff." This statement contradicted the preceding one, as it included slapping himself as part of the SIB behavior. The "Summary of Conditions presented 8/12/04," which reflected the outcome of Individual #18's above referenced behavioral assessment, did not support the QMRP's and Clinician's statements that blocking his hits to his head would escalate the behavior. No further assessment or supportive information was provided. Continued incidents of intense hits to his head had the potential to negatively impact the physical well being of Individual #18.	W 214		

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W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure written training programs provided clear and sufficient directions to staff on how to implement behavior programs for 5 of 21 individuals (Individual #6,11, 12, 19, and 20) whose behavior support programs were reviewed. This resulted in the potential for inconsistent application of techniques being utilized. The findings include: 1. Individual #20's PCP, dated 1/11/06, documented a 49 year old male diagnosed with severe mental retardation, anxiety disorder (not otherwise specified), right side hemiparesis secondary to infantile stroke, seizure disorder, Raynaud's Syndrome, severe migraine headaches, and osteoporosis. His PCP stated he was legally blind with complete retinal detachment in his right eye, and his left eye and his right little finger were absent because of his self injurious behavior (SIB). Individual #20's BSP, titled Managing Symptoms of Anxiety, updated 4/4/06, included the following definitions for SIB: - Bites to Self: "An incident of bites to self occurs when [Individual #20] successfully or unsuccessfully attempts to bite his wrist, arm, or hand area. This behavior is counted regardless of whether it produces injury."	W 234		

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W 234	Continued From page 106 - Head Hit: "An incident of head hitting occurs when [Individual #20] slaps, hits, scratches, or punches at his face or head area. This behavior also includes hitting head against objects. This behavior is counted regardless of whether it produces injury. This behavior is used to assess program and medications effectiveness as it poses the most significant protection from harm issue, is the behavior that is most closely correlated with his mental health and is a reaction to both internal and external stressors." Under the section titled Interventions for self injurious behaviors for arm biting and head hitting, it stated staff were to redirect or distract him. If he continued with greater intensity, staff were to say "[Individual #20] put your arms down" and block his arms. If he did not respond, staff were to say and tactile sign "[Individual #20] stop." If a mat was available, staff were to put it near him and say "[Individual #20] a mat is in front of you." The plan stated he would independently use the mat to lie down and calm himself. It was unclear if the above noted instructions were supposed to be followed for arm biting, head hitting, or both behaviors. Further, it was unclear what "redirect or distract him" and "greater intensity" meant. When asked, the QMRP stated on 6/15/06 from 9:00 a.m. - 1:00 p.m., it was not in the plan. 2. Individual #6's PCP, dated 2/15/06, documented a 52 year old male diagnosed with profound mental retardation, pervasive developmental disorder, autism, OCD, COPD, and was a Hepatitis B carrier.	W 234		

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W 234	Continued From page 107 His BSP, titled Reduce Symptoms of Obsessive Compulsive Disorder, revised 3/23/06, stated he engaged in pica behavior. Under the section titled Instructions to Staff, it stated staff were to keep the environment as free as possible of small inedible items, keep him involved in activities, attempt to have him carry something requiring both hands when transporting from one place to another, and watch for concealed items. If he attempted to swallow an item, staff were to sign and say "no" and shake their head side to side to indicate no. Under the subsection titled Medical Intervention Guidelines, it stated staff were to "Notify the nurse IMMEDIATELY if [Individual #6] swallows any items that is larger than a postage stamp or poses an immediate threat to [Individual #6's] safety such as metal objects (i.e. staples, nails, screws, paper clips, etc.,) or chemicals (e.g. Cal-Stat or cleaning liquids). If the item is chemical, bring the bottle or a sample of the item to the nurse. Notify the nurse in a TIMELY FASHION (when [Individual #6] returns to the living unit or a nurse is available at the off unit location) if [Individual #6] swallows a cigarette butt or inedible object smaller than a postage stamp. Indicate what the object was." When asked about the type of items that would require medical attention, the QMRP stated on 6/15/06 from 9:00 a.m. - 1:00 p.m., the plan did not contain specific items. When asked at what point staff were to intervene, the QMRP stated the expectation was to immediately intervene by blocking and verbally redirecting him and if the item was harmful, staff were to physically intervene. When asked where in the plan those	W 234		

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directions were specified, the QMRP stated they were not in the plan.

3. Individual #11's BSP, revised 6/27/05, stated he was a 12 year old male. His BSP included objectives to reduce assaults, destruction of property, leaving without permission, and attempts to leave without permission.

a. The plan's instructions for assaults stated Individual #11 was not to be placed in a prone restraint due to Osteopenia. However, the instructions for destruction of property included the use of a prone
restraint. When asked about the restraint during an interview on 6/15/06 at 3:05 p.m., the QMRP who had assisted on the unit stated the Clinical Director was working on program revisions for Individual #11 and the prone was not to be used.

b. The facility's HIS manual, revised 2004, stated the "restraint technique to take a person who is combative from point A to point B is called a "Two Person Transport Restraint and One Person Transport Restraint."

Individual #11's BSP instructions for LWOP stated staff were to use HIS transport back to the unit. When asked about the intervention during an interview on 6/15/06 at 3:05 p.m., the QMRP stated it was similar to an escort and that it was not restrictive. She stated the plan should state escort rather than transport.

The facility failed to ensure Individual #11's BSP instructions were clear and consistent regarding the type of interventions staff were to use.

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4. Individual #19 was a 25 year old female with diagnoses of bipolar disorder, post traumatic stress disorder, mild mental retardation and borderline personality. She was admitted to the facility on 4/5/06.

a. Individual #19's BSP, titled Manage Mental Health, dated 4/06, included an objective for her to have fewer than five episodes of anger outbursts for three consecutive months. Anger outbursts were defined, in the data section, as exhibiting two or more of the following behaviors within a fifteen minute period of time: verbal threats, loud voice, self-report of anger, self injurious behavior and destruction of property.

Under the section titled Instructions For Staff, it stated staff were to:
- Verbally block and redirect her by reminding her that she may take a break in a safe area.
- Remind her that she may request to talk with staff if she needs to talk about something.
- Remind her that she may use her weighted blanket to help calm.
- Staff will record each episode of anger outbursts on the behavior reporting form. An episode is defined in the data section.
- Staff will check the box for each behavior that occurred during the episode.

The instructions did not include what to do if the behaviors continued to escalate when redirected, or what to do if staff were unable to talk with her when she requested. It was unclear how staff were to determine if Individual #19 was speaking in a loud voice. The instructions stated staff were to remind her she could use her weighted blanket,

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however, the instructions did not tell them when they were to remind her.

Additional instructions, under DOP, stated staff were to remove the object she was destroying when possible. The instructions did not include how they were to take the item (verbal request, physically take the item, etc.).

The instructions for SIB stated staff were to minimize attention but did not include when or how staff were to intervene to provide for Individual #19's safety when she engaged in SIB.

b. The BSP included an objective for her to have fewer than five episodes of impulsivity for three consecutive months. Impulsivity was defined as two or more of the following behaviors within a fifteen minute time period: physical assault, suicide ideation, leaving without permission and interrupting staff.

Under the section titled Instructions For Staff, it stated:
- Staff will verbally block and redirect by reminding her she could take a break in a safe area.
- Remind her she may request to talk with staff if she needs to talk about something.
- Staff will record each episode of impulsivity on the behavior reporting form as defined in the data section.
- Staff will check the box for each behavior that occurred during the episode.

The instructions did not include what to do if the behaviors continued to escalate when redirected, or what to do if staff were unable to talk with her

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W 234	Continued From page 111 when she requested. The instructions for physical assault stated staff were to ensure safety to the target of the assault and to Individual #19. The instructions to staff did not include how to do this such as keeping the individuals separated, involving Individual #19 in another activity, etc. Suicide threats/ideation was defined as any verbal or written comment or statement "when she says she wishes to kill herself or that she will kill herself." The Instructions to Staff for Suicide ideation stated: - Staff will record data on the sleep data form 24 hours a day to track times she is sleeping, awake, or isolating. - Encourage her to sleep during the hours of 10:00 p.m. and 6:00 a.m. - Encourage her to avoid daytime naps. - Encourage her to exercise daily. - Encourage her to limit the amount of caffeine she consumes. The instructions did not include what staff were to do if she expressed, (verbally or written) suicidal ideation or threatened suicide. The instructions for LWOP stated: - Block and redirect from leaving. - Follow her (take a radio) if she continues to leave the unit. - Remind her of other ways to cope with what is bothering her. For example she may talk with staff, use relaxation skills, listen to music, or write.	W 234		

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W 234	Continued From page 112 The program did not include a definition for LWOP. The second step in the instructions for LWOP stated to follow her when she left the unit. However, the corresponding behavior reporting form stated LWOP was when she left the area without letting staff know. It was unclear if staff were to document LWOP as leaving the unit or an area in the unit. The instructions did not include how long staff were to follow her, when physical interventions were to be used, and the purpose of the radio (to ask for assistance, report location to the unit, etc.). Further, an SER (#06-748) documented that on 5/19/06, the weighted blanket was determined to be an effective intervention. However, no other documentation could be found related to its use. An SER (#06-749) documented "The team had an emergency meeting on 5/24/06 to come up with a plan to assist with the reduction of injuries during restraint. The Clinician will obtain a temporary consent for chemical restraint until the IST team meets on 5/31/06." It was unclear why the use of the blanket had not been systematically tried and proven to be ineffective prior to the team's decision to obtain consent for chemical restraints on 5/24/06. The QMRP was interviewed on 6/16/06 at 8:30 a.m., and acknowledged the program did not provide clear instructions to staff when to use the weighted blanket or other interventions. When asked, the QMRP stated there was no further documentation of using the weighted blanked. 5. Individual #12's BSP, revised 3/17/06, stated he was a 12 year old male. His BSP included	W 234		

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W 234	Continued From page 113 objectives for physical assaults, psychotic behavior, destruction of property, and skin picking. The "Data Collection and Definitions" section of the report defined destruction of property as "any deliberate ripping, mutilating or breaking of any property." However, the "Instructions to Staff" section of the plan did not include instructions to staff regarding destruction of property. When asked about the lack of instructions, the QMRP stated on 6/16/06 at 8:02 a.m. she would need to talk to the Clinician. At that time, the Acting Administrator, who was present, stated the instruction were not included in the plan. The facility failed to ensure Individual #12's BSP specified the methods to be used to implement the objectives in the plan.	W 234		
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the type of data collected was sufficient to determine the efficacy of the intervention strategies for 9 of 21 individuals (Individuals #5, 6, 9, 11, 12, 15 - 17, and 19) whose behavior plans were reviewed. By not ensuring appropriate data collection, the	W 237		

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facility would not be able to make objective decisions regarding the individuals' success or lack of success. The findings include:

1. The facility used a "Behavioral Reporting Form" to document maladaptive behaviors. The form consisted of 4 columns which included behavior, antecedent, consequence, and other information. The antecedents, behaviors and consequences as per the individuals' BSPs, were listed within their respective column.

a. For example, the behavior column listed physical assault, attempted assault, skin picking, psychotic behavior and DOP for Individual #12, who was admitted to the facility on 2/3/06. His "Antecedent" column listed teased by peer, threatening/yelling, requested to wait and task request. The "Consequence" column listed problem solved, the STAR system, ignore, redirection, restraint, and block. The "Other Information" column asked was the client injured, name of client and staff victims (if any), if there was immediate protection from harm, staff initials and additional comments. When a maladaptive behavior occurred, staff were to mark the appropriate boxes in each column. This type of data sheet did not provide the facility with enough information to determine the efficacy of the intervention. For example, Individual #12's behavior data for 4/7/06 was reviewed. At 6:05 a.m., staff had placed a mark in the following boxes:

Behavior -
Psychotic behavior
Antecedent-
No marks had been placed in the antecedent

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W 237	Continued From page 115 column. Consequence - No marks had been placed in the consequence column. Other information - Additional comments stated "Raspberry sounds making weird sounds." The above mentioned data was not clear in reflecting Individual #12's psychotic behavior, the antecedent events or the intervention strategies the staff had employed in response to the behavior. When asked about the data, on 6/16/06 at 8:02 a.m., the Acting Administrator stated she understood the need for ABC data for assessment when the individual was new to the facility and they would expect ABC data. b. Individual 12's behavior data also documented the following: On 3/10/06 at 3:35 p.m., Individual #12 was placed in a stand and sit restraint for engaging in destruction of property. No ABC data was provided to clarify the sequence of events. No antecedent was indicated either by narrative or check mark data, and no intervention was documented other than restraint. When asked about the data, during an interview on 6/15/06 at 3:05 p.m., the QMRP who had assisted on the unit stated he thought the staff had probably attempted to block the DOP, and LWOP and assault occurred resulting in the restraint.	W 237		

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c. On 04/12/06 at 10:35 a.m., check marks were placed in the physical assault, attempted assault, and psychotic behavior columns. In the check box under "skin picking" staff had written "scratching grabbing self." The ABC data stated "[Individual #12] was scheduled to go shopping with [staff's name]. She was in the group to get him he was cued to get ready to go with her he said no I'm going to see the nurse he ran out of unit to the nurses station he ran into her office demanding more cream she stated she just gave him some at (10:15 AM) he said 'it still f**king itches' [nurses name] tried to problem solve by telling [Individual #12] if he wanted to go shower she could reapply the medication [for eczema] he then tried to get to the med cart when redirected he stuck his hands down his pants screaming 'it itches' he was then physically redirected from the nurses station he was laying on the floor screaming it 'f**king itches' he was spinning around on the floor kicking any one he could reach he made his way out of the bld. took off to bld 2 stated he wanted to go golfing trying to climb trees sat down in road HIS escort to safety he assaulted HIS to sit [sic]."

On 6/16/06, at 8:02 a.m., when asked how staff were to differentiate skin picking as a medical issue as opposed to a psychiatric issue, the QMRP stated, "When he is picking as a mental illness issue he is not expressing any concern." The QMRP further stated Individual #12 would tell staff if he was itching. She stated, "If he says he is itching they would not count it as mental illness symptoms." However, the "Data Collection and Definitions" section of his BSP, revised 3/17/06 gave the definition of skin picking as, "Any time that [Individual #12] scratches, rubs until red, or

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picks at new or already existing scabs or pieces off skin." The data did not provide a clear distinction between "skin picking" as a medical symptom as opposed to a psychiatric symptom.

Additionally, the "Data Collection and Definitions" section of the plan stated skin picking data would be collected as follows: "One 10 minute probe will be run once daily on swing shift. A new incident will be recorded when there has been an absence of picking for 2 minutes between picks." As stated, the data collection system would not allow staff to capture adequate information as it was designed to track one specific 10 minute period of the day. Furthermore, the definition of a "new incident" was the "absence of picking for 2 minutes" which would not allow an accurate picture of the data captured within the defined time segment (i.e., continuous picking during the 10 minute probe, and picking for 30 seconds then stopping, would both equal a "1" on the data sheet).

The facility failed to ensure Individual #12's data was collected in a form and frequency that would allow the IDT to make appropriate recommendations regarding his intervention strategies.

2. Individual #5's behavior data sheets did not provide the facility with sufficient information to determine the efficacy of the intervention. Examples include but are not limited to the following:

a. On 4/24/06 he was placed in a sit restraint from 9:50 to 10:00 p.m. because he "interfered [sic] with [Individual #11] during [Individual #11's]

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restraint. Documentation related to how he interfered with the restraint was not available. Without such documentation it would not be possible for the facility to determine if the restraint was warranted, and how to prevent similar incidents in the future.

b. On 3/1/06 he was placed in a stand, sit, and prone restraint from 2:43 to 3:01 p.m. for LWOP and DOP. His 11/18/05 program instructions stated staff were to block/redirect and follow HIS if he became assaultive. However, assaultive behavior was not documented. Without such documentation it would not be possible for the facility to determine if the restraint was warranted.

3. Individual #16's raw behavior data sheets did not provide the facility with sufficient information to determine the efficacy of the intervention. Examples include but are not limited to the following:

a. On 4/3/06 at 9:05 a.m., Individual #16 left without permission. No other information related to the behavior (antecedent, consequence, etc.) was documented.

b. On 4/2/06 at 11:40 a.m., Individual #16 left without permission. An "R" was marked in the problem solving column and a mark was placed in the Star System column, indication it was used. Information related to the behavior's antecedent was not documented.

4. Individual #11's behavior data sheets did not provide the facility with sufficient information to determine the efficacy of the intervention. For example, on 4/23/06 at 2:15 p.m., Individual #11

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left without permission. Staff documented redirection had been used and wrote "ABC" in the comments section. However, no corresponding ABC data was documented regarding the incident.

5. Individual #15's behavior data sheets did not provide the facility with sufficient information to determine the efficacy of the intervention. For example, on 4/18/06 at 2:55 p.m., check marks were placed in the DOP and LWOP columns. Staff had written "wanted something" in the antecedent columns. Check marks were placed in the "problem solved" and "redirection" columns, and the "other information" section listed "kitchen wall" as the item destroyed. No ABC data was provided to clarify the sequence of events. It was not clear what activity Individual #15 was involved in, what item was wanted but unobtainable or why, the definition or description of LWOP, what type of redirection was attempted (verbal/physical, redirection to task, to calm down, etc.), or which intervention strategy was attempted for which behavior (i.e., was redirection used for DOP, LWOP, or both). Also, it was unclear if the check mark in the "problem solved" column was to indicate problem solving techniques had been used as an intervention, or if the issue was resolved.

6. Individual #6's PCP, dated 2/15/06, documented a 52 year old male diagnosed with profound mental retardation, pervasive developmental disorder, autism, OCD, COPD, and was a Hepatitis B carrier.

His BSP, titled Reduce Symptoms of Obsessive Compulsive Disorder, revised 3/23/06, stated he

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engaged in pica behavior. Under the section titled Instructions to Staff, it stated staff were to keep the environment as free as possible of small inedible items, keep him involved in activities, attempt to have him carry something requiring both hands when transporting from one place to another, and watch for concealed items. If he attempted to swallow an item, staff were to sign and say "no" and shake their head side to side to indicate no.

Under the section titled Data Collection, it stated each incident of pica was to be recorded. Pica was defined as "ingesting or attempting to ingest non-edible items that are larger than a postage stamp or pose on [sic] immediate threat to [Individual #6's] safety if ingested such as metal objects (i.e. staples, nails, screws, paper clips, etc.) or chemicals (e.g. Cal-Stat or cleaning liquids). Cigarette butts do not pose an immediate threat to [Individual #6's] safety."

The corresponding BRF contained the following four columns: Behavior, Antecedent, Consequence, and Other Information. The BRF stated antecedent, behavior, and consequence data was only collected for threats, physical assault, and self injurious behavior. All other data was collected via a check mark under the appropriate column.

Individual #6's BRFs, dated 2/06-5/21/06, showed assault, attempted assault, pica, inappropriate touch, and inappropriate disposal of items were listed under the "Behavior" column. Told no/told to stop, caused by peer/teased, and waiting/activity change were listed under the "Antecedent" column. Redirection, separation,

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block, and ignore were listed under the "Consequence" column. Client injured (yes/no), immediate protection from harm (yes/no), client victim, staff victim, and staff initials were listed under the "Other Information" column.

Individual #6's BRF showed check-marked data which did not comprehensively reflect antecedent events, behavior, and the consequences of the behavior. Further, there was no documentation on Individual #6's response to the interventions. Examples include, but are not limited to, the following:

2/8/06 at 3:58 p.m.:
- Behavior: "Pica." There was no other documentation that identified what the item(s) was.
- Antecedent: "During transport" was hand-written in. However, no information was documented as to how the individual had obtained the object and what was occurring at the time th pica took place.
- Consequence: "Redirection." It was unclear what activity Individual #6 had been redirected to, what type of redirection was used, and there was no information on Individual #6's response to the intervention.

2/14/06 at 11:50 a.m.:
- Behavior: "Pica." There was a notion which stated "paper at voc." There was no other information that identified how much paper was eaten.
- Antecedent: There was no entry under this column.
- Consequence: There was no entry under this column. It was unclear whether or not staff intervened.

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2/21/06 at 7:52 p.m.:
- Behavior: "Pica." There was no other documentation that identified what the item(s) was and where it was obtained.
- Antecedent: "snack/meds" was written in. No other information describing factors, such as noise level, staff proximity, etc., was documented.
- Consequence: "Redirection." It was unclear what "redirection" meant and there was no information on Individual #6's response to the intervention.

2/28/06 at 11:34 p.m.:
- Behavior: "Pica." There was no other documentation that identified what the item(s) was and where it was obtained.
- Antecedent: "After lunch" was hand-written in. No further details were provided.
- Consequence: "Redirection, Block." It was unclear what "redirection" meant or what type of block was used and what it was used for. There was no information on Individual #6's response to the intervention.

2/28/06 at 4:50 p.m.:
- Behavior: "Pica."
- Antecedent: "Obsessing on cups while I was gathering garbage to take out. [Individual #6] got a top of a ink pen and ate it."
- Consequence: There was no entry under this column. It was unclear whether or not staff intervened, and if so, how.

3/8/06 at 5:05 p.m.:
- Behavior: "Pica." There was a notation showing it was a piece of bark. There was no information on the size of the piece of bark he ingested and

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where/how it was obtained.
- Antecedent: "Told no/Told to stop."
- Consequence: "Redirection, Block." It was unclear what "redirection" meant or what type of block was used and what it was used for. There was no information on Individual #6's response to the intervention.

3/10/06 at 4:30 p.m.:
- Behavior: "Pica" was checked twice. There was a notation showing it was two cigarette butts.
- Antecedent: "Walking between build" was hand-written in. Information specific to Individual #6's behaviors, interactions, etc. prior to the pica incident was not documented.
- Consequence: "Redirection." It was unclear what "redirection" meant and there was no information on Individual #6's response to the intervention.

3/12/06 at 11:50 a.m.:
- Behavior: "Pica." There was a notation showing it was a poker chip.
- Antecedent: "OCD" was hand-written in. Further description of antecedents was not documented.
- Consequence: "Redirection, Block." It was unclear what "redirection" and "block" meant and there was no information on Individual #6's response to the intervention.

3/20/06 at 3:20 p.m.:
- Behavior: "Pica." There was no other documentation that identified what the item(s) was and where/how it was obtained.
- Antecedent: "Told no/Told to stop" It was unclear if this occurred in response to Individual #6's pica behavior or if it was related to another event.

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- Consequence: "Redirection." It was unclear what "redirection" meant and there was no information on Individual #6's response to the intervention.

4/5/06 at 9:10 p.m.:
- Behavior: "Pica" was checked 6 times. There was a notation which stated "picking scabs on left wrist and eating."
- Antecedent: "No reason" was hand-written in. No other antecedent information was documented.
- Consequence: "Redirection, Block." It was unclear what "redirection" and "block" meant and there was no information on Individual #6's response to the intervention.

4/12/06 at 5:15 p.m.:
- Behavior: "Pica." There was no other documentation that identified what the item(s) was and where/how it was obtained.
- Antecedent: "Waiting" was circled. Information regarding Individual #6's behavior while waiting, how long he had been waiting, and what he was waiting for, etc., was not documented.
- Consequence: "Redirection." It was unclear what "redirection" meant and there was no information on Individual #6's response to the intervention.

4/23/06 at 2:10 p.m.:
- Behavior: "Pica." There was a notation which stated "change of shift, piece of paper." There was no other information on how much paper he ingested and where/how it was obtained.
- Antecedent: "Waiting/Activity change." Information regarding Individual #6's behavior while waiting, how long he had been waiting, and

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what he was waiting for, etc., was not documented.

- Consequence: "Redirection." It was unclear what "redirection" meant and there was no information on Individual #6's response to the intervention.

5/6/06 at 1:20 p.m.:
- Behavior: "Pica." There was a notation that stated "[Individual #6] pica'd ½ dime size stick."
- Antecedent: "Told no/Told to stop" was checked with a notation that stated Individual #6 was on his way to the kitchen to put the stick in the garbage.
- Consequence: "Redirection, Block" was marked with a notation that stated "took stick away, redirected to activity in dayhall." It was unclear whether or not Individual #6 ingested the stick and there was no information on his response to the staff person's intervention.

5/21/06 at 1:43 p.m.:
- Behavior: "Pica." There was a notation which stated "pica'd tip of ink pen." There was no other information on which tip of the pen was ingested.
- Antecedent: "Told no/Told to stop" was checked with a notation that stated Individual #6 was in the day hall and got a red ink pen off the desk.
- Consequence: "Redirection, Block" was marked with a notation that stated "Block, redirected to puzzles." There was no information on Individual #6's response to the intervention.

The lack of specific comprehensive data regarding the antecedent events, the behavior, and the consequence of the behavior, impeded the IDT's ability to assess effectiveness of

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W 237	Continued From page 126 Individual #6's beahviroal interventions. The facility would not be able to identify what had precipitated the behavior, what exact behavior occurred, whether or not the staff implemented the appropriate intervention and whether or not the intervention was effective. The facility failed to ensure the type of data collected for Individual #6's maladaptive behaviors provided sufficient information to adequately assess the efficacy of the intervention strategies. 7. Individual #9's PCP, dated 3/30/06, documented a 33 year old male with diagnoses of inappropriate sexual activity including pedophilia, impulse control disorder NOS, PTSD, and mild mental retardation. His training plan, dated 3/30/06 and titled "Seek assistance when upset or feels like isolating," stated he had a history of depression (isolating in his room, avoidance or refusal to participate in programs or activities, shutting down in groups, and anger outbursts). The corresponding objective stated "{Individual #9} will describe two behaviors he engages in that warn him that he is depressed and identify at least two alternative behaviors to help him come out of his depression 90% of daily trials per month for six consecutive months." On 6/14/06 at 11:20 a.m., a direct care staff was asked how he documented behaviors for Individual #9. Staff produced a behavior rating form that listed sexual misconduct, physical assault, attempted assault, verbal threats, offensive language, and SIB. The QMRP stated,	W 237		

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on 6/14/06 at 1:00 p.m. the data sheet was the old data sheet and should have been revised.

The data collection section of the training plan stated if Individual #9 responded correctly by identifying two behaviors that were warning signs of depression and two alternative behaviors that he could choose to help change his mood, he would receive verbal praise and a plus (+) on the data sheet. If he was unable to identify warning behaviors or alternative behaviors a minus (-) would be recorded. If he did not respond, a refusal would be documented with an "R". It was unclear how a plus, minus, or a refusal data collection system would be sufficient to inform the IDT of whether he was experiencing signs and symptoms of depression, what the signs and symptoms were that he had identified, and what the appropriate alternative behaviors were that he had identified.

During an interview on 6/14/06 at 12:55 p.m. the QMRP nodded her head in agreement when told the data collected did not reflect the identified behaviors of depression.

The facility failed to ensure the type of data collected for individuals' maladaptive behaviors provided sufficient information to adequately assess Individual #9's depression.

8. Individual #19 was a 25 year old female with diagnoses of bipolar disorder, post traumatic stress disorder, mild mental retardation and borderline personality. She was admitted to the facility on 4/5/06.

Individual #19's BSP, titled Manage Mental

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Health, dated 4/06, included an objective for her to have fewer than five episodes of anger outbursts for three consecutive months. The section titled "Episodes" stated data would be collected for each episode. Anger outbursts were defined, in the data section, as exhibiting two or more of the following behaviors within a fifteen minute period of time, verbal threats, loud voice, self-report of anger, self injurious behavior and destruction of property. A new episode would begin when Individual #9 had an absence of behaviors for fifteen minutes. Furthermore it was unclear if she demonstrated the same behavior two or more times if it would be documented as an "Outburst".

a. The behavior columns for "Outburst" listed verbal threat, loud voice, SIB and DOP. A column for self-reporting of anger was not included. The columns for "Impulsivity" listed physical assault, interruption, suicide ideation, hitting/or banging head and LWOP. The "Antecedent" column listed asked to do something, told no/asked to stop, being ignored, and previous behavior. The consequence column listed problem solved, block/redirection, ignore, restraint Y=yes N=no. The "ABC Narrative" section included an antecedent section, a behavior section and a consequence section. In the antecedent section staff were to state what had happened prior to the behavior. In the behavior section they were to describe the behavior in detail. In the consequence section staff were to document what they did following the behavior. When a maladaptive behavior occurred, staff were to mark the appropriate boxes in each column. This type of data sheet did not provide the facility with enough information to determine the efficacy of

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W 237	Continued From page 129 the intervention. For example, Individual #19's behavior data for 5/23/06 was reviewed. At 10:24 a.m., staff had placed a mark in the following boxes: Antecedent - Told no/ asked to stop Outburst Loud voice SIB attempts x 2 Impulsivity - Physical assault Hitting/or banging head Consequence - Block/Redirection Restraint The ABC antecedent narrative stated Individual #19 was upset in her room and staff had asked her not to hit her already bruised knee. The behavior section stated she was hitting her knee and refused to stop and "hitting her head on the floor." It also stated when she was in a "prone she bite (sic) a staff and scratched one." The consequence section stated she had refused to problem solve and continued hitting staff. Individual #19 was placed in a HIS sitting restraint and then a prone restraint. The above mentioned data was not clear in reflecting why Individual #19 was upset in her room and hitting her knee, the number of times she hit her knee, the number of times she assaulted staff (staff had written 1 staff was bit	W 237		

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and 1 was scratched), how staff attempted to problem solve, and how many times she hit her head on the floor. The section for SIB attempts was marked 2, however, there was no documentation of the type of SIB attempted (hitting her head on the floor or hitting her knee). On the back of Individual #19's data sheet, staff indicated she had been placed in an emergency prone restraint from 10:24 p.m. to 11:04 p.m. as a result of this incident.

The QMRP stated, on 8/16/06 at 8:21 a.m., with the current data collection system, an "outburst" for an hour, without a 15 minute calm, would be counted as 1 incident, the same as an outburst for 5 minutes or less.

Without comprehensive data regarding the antecedent events, the behavior, and the consequence of the behavior, it would not be possible for the facility to adequately assess whether Individual #19's behavior intervention strategies were adequate. The facility would not be able to identify what had precipitated the behavior, what exact behavior had occurred and for how long, whether the staff had implemented the appropriate intervention, and if the intervention was effective.

9. Individual #17's BSP, updated 5/18/05, stated he was a 13 year old male. His BSP included objectives for assaults, leaving without permission, obsessive episodes, and destruction of property.

a. His BSP stated the "program was updated on 5/18/05 to add positive interventions/replacement behaviors to help provide alternatives to

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[Individual #17's] obsessing/fixating." The plan included an objective for "Obsessing" which stated he would "decrease his obsessive episodes to less than 30 minutes for 20 data probes for 3 consecutive months..." The data section of his BSP stated staff were to run a 30 minute data probe once a day on both the day and swing shift. They were to record how long he spent obsessing on an object/activity and if he was redirected, how long did he spend in the activity staff redirected him to.

The plan did not include instructions to staff as to when or how often they were to attempt to redirect Individual #17 (i.e., continual attempts to redirect, every 5 minutes during the 30 minute probe, every 10 minutes, etc.).

His obsessing behavior summary data documented the following:

4/05: 16
5/05: 25
6/05: 22
7/05: 35
8/05: 32
9/05: 24
10/05: 35
11/05: 45
12/05: 52
1/06: 40
2/06: 13
3/06: 17
4/06: 28
5/06: 19

It was unclear what the summary data numbers meant (i.e., average number of minutes spent

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W 237	Continued From page 132 obsessing, total number of probes in which he obsessed for a full 30 minutes, or total number of probes in which he obsessed under 30 minutes). When asked, the Clinician stated on 6/19/06 at 3:00 p.m., he thought the numbers were reflective of the number of probes in which Individual #17 had obsessed for 30 minutes but he was unsure as he had not developed the data system. He further stated the data collection related to Individual #17's obsessing had recently been revised. b. Individual #17's behavior data sheets did not provide the facility with sufficient information to determine the efficacy of the intervention. Examples include, but are not limited, to the following: - On 4/17/06 he had been placed in a sit then prone restraint for assaultive behavior from 6:04 to 6:40 p.m. No ABC data related to the assault was documented. - On 4/17/06 at 4:42 p.m., a check mark was placed in the LWOP column, the antecedent event had been checked as "wanted something, can't have," and the "other information" column stated he was "obsessing over a helmet." The consequence section indicated he had not been restrained. However, no other consequence information (problem solving, relaxation, etc.) was documented.	W 237		

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W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure individuals received training and services consistent with their PCPs for 7 of 18 individuals (Individuals #9, 13, and 21 - 25) whose behavior and training programs were reviewed. This resulted in individuals receiving inconsistent training which impeded the acquisition of skills necessary for increased independence. The findings include: 1. Individual #21's PCP, dated 1/18/06, documented a 24 year old male diagnosed with profound mental retardation, intermittent explosive disorder, seizure disorder, cerebral palsy with spastic quadriplegia, and scoliosis of the spine. He used a wheelchair for ambulation and mobility. a. Individual #21's BSP, updated 4/20/06, stated staff were to provide him sensory experiences throughout his day by "briefly massage his leg [sic], neck or shoulders for several seconds ..." During observations conducted on 5/18/06, 5/19/06, and 5/20/06 for a cumulative 6 hours 20 minutes, staff were not noted to provide him with	W 249		

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W 249	Continued From page 134 brief massages as identified in his BSP. b. Individual #21's service plan, titled Provide/Maintain Wheelchair and Support Devices, revised 5/3/06, stated staff were to "Apply the wheelchair chest strap when [Individual #21] is involved in active treatment situations that required him to be in optimal positioning for function, such as meals or vocational activities." During observations conducted on 5/18/06, 5/19/06, and 5/20/06 for a cumulative 6 hours 20 minutes, staff were not noted to provide Individual #21 with his chest strap. During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated she did not think Individual #21 had a chest strap. c. Individual #21's training plan, titled Mealtime Training, revised 1/18/06, stated staff were to periodically offer him a warm washcloth to wipe his hands in order to encourage him to use his hands. Further, his CFA, dated 11/9/05, stated he was able to hold a spoon, scoop food, place the food in his mouth, and drink from a cup with full physical assistance. During an observation on 5/18/06 from 6:50 - 8:45 a.m. Individual #21 was noted to be fed his breakfast. When asked, present staff stated he had an objective to only hold a spoon for 5 seconds. During an observation on 5/19/06 from 4:00 - 6:10 p.m. he was noted to be fed his dinner by staff. When asked, present staff stated he had an objective to only hold a spoon for 5 seconds. During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated staff were to use	W 249		

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physical assistance with Individual #21, use the warm washcloth, and staff were not suppose to feed him.

d. Individual #21's training plan, titled Increase Work Production, revised 1/18/06, stated when he was sitting in front of the can crusher with several cans within his reach, he was able to, with one light physical prompt, initiate the sequence to reach out and pick up a can, place it in the crusher, close the door, and push the switch thereby crushing the can. The plan stated he would complete the sequence, initiated by a light physical paired with verbal prompt ("staff say, "[Individual #21], start crushing cans") two to three times before he refused by waving his hand. Under the section titled Instructions/Set-up, it stated staff were to set up the can crusher by placing five to 10 cans that were accessible to Individual #21 and to assist him to sit in front of the can crusher.

During an observation on 5/19/06 from 10:25 - 11:40 a.m. at the vocational classroom, Individual #21 was noted to be sitting in the middle of the classroom, leaned forward and to his right side, and with his head on the armrest of his wheelchair. A staff person attempted to get him to hold a soda can and he did not respond. The staff put the soda can on the floor and asked him to un-cross his feet which he did. Staff asked him to kick the can and he did not respond. A second staff person asked him a question and he did not respond. The second staff person picked up the soda can from the floor and set it on a nearby counter and walked away. The first staff person obtained another soda can and assisted him to feel it as the staff said "crush can". He did not

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respond. The staff person placed the soda can on the floor and informed him the staff person would return in a few minutes.

During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated his training plan should have been implemented.

e. Individual #21's PCP included a list of prioritized goals. The Priority Key showed "A" goals were high priority with training programs in the current year and "B" goals were to be "prompted to perform as much as possible during regular daily activities." His list of "B" goals included the following that were not noted to be implemented during observations conducted on 5/18/06, 5/19/06, and 5/20/06 for a cumulative 6 hours 20 minutes: wipe face with napkin, set own place at table, clear own place from table, use hands for functional activities, participate in independent table activities, and engage in a leisure or a table activity with a peer. For example, on 5/18/06 at 8:00 a.m., Individual #21 was sitting in his wheelchair, leaned forward and to his right side, and his head was on his lap tray. At 8:10 a.m., a staff positioned his wheelchair at the dining table. He remained in the same forward position with his head on the lap tray until 8:30 a.m. At 8:30 a.m., he was fed his breakfast meal by a staff person. No "B" goals were noted to be implemented.

2. Individual #22's PCP, dated 11/2/05, documented a 57 year old female diagnosed with severe mental retardation, organic brain syndrome, seizure disorder, and dementia NOS (not otherwise specified).

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W 249	Continued From page 137 a. Individual #22's training plan, titled Maintain Sleep Hygiene, revised 11/3/05, stated staff were to interrupt daytime napping except immediately after lunch, encourage her to exercise regularly during the morning and afternoon, and "The only place where [Individual #22] should sleep is in her bed (not in communal furniture)." During an observation on 5/18/06 from 6:50 - 8:45 a.m., Individual #22 was noted to lay on the couch during all but 5 minutes (when she took her medications in the medication room) of the observation. When asked, present staff stated she had dementia and was retired. During an observation on 5/20/06 from 1:30 - 2:30 p.m., she was noted to lie on the couch during the entire observation. Staff were not noted to prompt or encourage her to participate in any kind of exercise as identified in her training plan. b. Individual #22's BSP, titled Reduce Symptoms of Organic Brain Syndrome - Dementia NOS, updated 1/10/06, documented her replacement behavior was for maintaining social integration skills by trading objects. The plan stated staff were to get her distraction box while ensuring staff was within Individual #22's direct line of sight and staff were to sit at a table, on a mat, or on a chair. Staff were to take an item out of her distraction box, try the item on (if clothing) and model having a good time with the item. The plan stated "Do NOT approach [Individual #22] unless she initiates an interaction." When she expressed an interest by coming to the staff, staff were to give her the object or place it on her as appropriate for the object. Once she had a	W 249		

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couple of items, staff were to encourage her to trade for an additional item.

During an observation on 5/20/06 from 1:30 - 2:30 p.m., Individual #22 was sitting with her legs up on the couch and a staff assisted her to put a wig on then had her look at herself in a hand-mirror. The staff person wrapped a green scarf around the top of the wig, put a hat on top of the wig, and handed her a sting of beads. Individual #22 removed the hat/scarf/wig combination, dropped it on the floor, and proceeded to lie down on the couch. A staff held the hand mirror such that she could see her reflection. She reached for it and staff reached in to her nearby box (on the floor) and offered her the wig and scarf. She did not respond. Staff offered her the mirror again and she pushed it away. Within 30 seconds, she sat up and the staff put the wig on her and handed her the mirror. She took the mirror and threw it on the floor.

Individual #22's replacement behavior, as identified in her BSP, was not noted to be implemented as written.

c. Individual #22's BSP, titled Reduce Symptoms of Organic Brain Syndrome - Dementia NOS, updated 1/10/06, stated her "non-targeted" behavior was lying on the ground. The plan stated "she may not always choose the most appropriate place (safety or dignity)." Staff were to encourage her to make a more appropriate choice (bean bag chair, yoga mat, or moving to a couch) by prompting her every 15 minutes.

During an observation on 5/19/06 from 4:00 - 6:10 p.m., Individual #22 was guided to the outside

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patio area. She walked from the patio to an area that contained a lounger and no grass. There was a piece of carpet on the ground which was covered with dirt. She proceeded to sit on the dirt-covered carpet and then laid down on it. A staff person arrived and she sat up. The staff person applied sunscreen to her arms, face, and neck, and then left the area. Periodically, Individual #22 sat up, ran her fingers through the dirt, and then laid down again. When asked, present staff stated periodically, she would sit on the lounger; usually she would seek out areas with no grass and she liked to sit in the dirt.

Individual #22's non-targeted behavior plan, as identified in her BSP, was not noted to be implemented as written.

d. Individual #22's PCP included a list of prioritized goals. The Priority Key showed "A" goals were high priority with training programs in the current year and "B" goals were to be "prompted to perform as much as possible during regular daily activities." Her list of "B" goals included the following that were not noted to be implemented during observations conducted on 5/18/06, 5/19/06, and 5/20/06 for a cumulative 6 hours 20 minutes: pick hair accessories, recognize potential hazards, participate in group activities, play/interact cooperatively with others, sit near others during a table activity, demonstrate additional signs (sign language), and participate in an appropriate retirement activity schedule.

3. Individual #6's PCP, dated 2/15/06, documented a 52 year old male diagnosed with profound mental retardation, pervasive developmental disorder, autism, and OCD.

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Individual #6's PCP included a list of prioritized goals. The Priority Key showed "A" goals were high priority with training programs in the current year and "B" goals were to be "prompted to perform as much as possible during regular daily activities."

His list of "B" goals included the following that were not noted to be implemented during observations conducted on 5/18/06, 5/19/06, and 5/20/06 for a cumulative 6 hours 20 minutes: use a knife, indicate own choice of activities/events he would like to participate in, respond to conversation, join small group activities, expand leisure activities, and participate in an exercise routine.

For example, during an observation on 5/18/06 from 6:50 - 8:45 a.m., Individual #6 was noted to sit at the dining table and independently put together large-piece puzzles for 52 minutes. Staff were not noted to attempt to expand Individual #6's leisure activities, encourage him to respond to conversation, or encourage his participation to exercise.

During an observation on 5/19/06 from 4:00 - 6:10 p.m., Individual #6 was offered a large-piece puzzle by a staff person. He carried it to the table, sat down, and proceeded to independently put the puzzle together. At 4:45 p.m., a staff person proceeded to take the puzzle apart and put the pieces in its box. Individual #6 put the puzzle away and returned to the table with another puzzle. Staff were not noted to encourage him to join small group activities, attempt to expand Individual #6's leisure

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W 249	Continued From page 141 activities, encourage him to respond to conversation, or encourage his participation to exercise. During an observation on 5/19/06 from 4:00 - 6:10 p.m., a staff person put mustard and catsup on two slices of bread and added ground turkey to make a sandwich. The staff cut the sandwich into bite-size pieces and placed a serving of potatoes and a serving broccoli on the plate. The staff cut the potatoes and broccoli in smaller pieces and gave the plate to Individual #6. Individual #6's participation to prepare his food and use a knife was not elicited by the staff. During an observation on 5/20/06 from 1:30 - 2:30 p.m., a staff person put a large-piece puzzle on the table. Individual #6 was noted to sit at the dining table and independently put together large-piece puzzles for 40 minutes. Staff were not noted to encourage him to join small group activities, attempt to expand Individual #6's leisure activities, encourage him to respond to conversation, or encourage his participation to exercise. 4. Individual #25's PCP, dated 8/17/05, documented a 41 year old male diagnosed with profound mental retardation, major depression, organic brain syndrome, Type 2 diabetes, and he was legally blind and deaf. Individual #25's PCP included a list of prioritized goals. The Priority Key showed "A" goals were high priority with training programs in the current year and "B" goals were to be "prompted to perform as much as possible during regular daily activities."	W 249		

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W 249	Continued From page 142 His list of "B" goals included the following that were not noted to be implemented during observations conducted on 5/18/06, 5/19/06, and 5/20/06 for a cumulative 6 hours 20 minutes: increase social awareness, accept/pass items during group activities, actively participate in independent table activities, initiate one play/leisure activity, and actively participate in a table activity with a group. For example, during an observation on 5/19/06 from 4:00 - 6:10 p.m., Individual #25 was noted to be sitting in his recliner which was located in his bedroom and his head was down. A staff assisted him to put on his headphones and then left his room. He remained in that position for 39 minutes. Staff were not noted to encourage him to participate in independent table activities or and in a table activity with a group. During an observation on 5/20/06 from 1:30 - 2:30 p.m., Individual #25 sat in his recliner which was located in his bedroom and his head was down. He was wearing his headphones and rocking back and forth in the recliner. A staff person walked into and out of his bedroom. He continued to sit in his recliner with his head down during the entire observation. Staff were not noted to attempt to increase his social awareness, encourage him to participate in independent table activities, or encourage him to participate in a table activity with a group. During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated if Individual #25 was sitting in his recliner with his head down, he was probably asleep.	W 249		

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5. Individual #23's PCP, dated 12/7/05, documented a 56 year old male diagnosed with severe mental retardation, organic mood disorder, organic anxiety disorder, and seizure disorder.

a. Individual #23's training plan, titled Reduce thumb-sucking behavior, dated 12/7/05, stated "He is most likely to display this behavior when he is not interacting with others or engaged in an activity...This continues to be a training need for [Individual #23] as the behavior is not age appropriate and is construed to be a dignity issue." The plan stated that when he was sucking on his thumb, staff were to redirect him to the scheduled activity.

During an observation on 5/19/06 from 4:00 - 6:10 p.m., Individual #23 wandered around the living area. Occasionally, he sat cross-legged in a recliner and rocked back and forth. He was noted to periodically have his left thumb in his mouth. At 4:44 p.m., a staff person talked to him for no more than thirty seconds and then walked away. He continued to sit cross-legged in the recliner and periodically put his left thumb in his mouth for 35 minutes. From 4:50 - 5:26 p.m., he sat at the dining table. He was noted to scream occasionally and periodically, he had his left thumb in his mouth.

During an observation on 5/20/06 from 1:30 - 2:30 p.m., Individual #23 returned from his walk at 2:03 p.m. and sat in the recliner in the living area. Periodically, he rocked back and forth in the recliner and had his left thumb in his mouth. At 2:21 p.m., a staff talked with him for

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approximately 10 seconds and left the area. He remained in his recliner and periodically, rocked back and forth in the recliner and put his left thumb in his mouth, until the observation ended at 2:30 p.m.

Staff were not noted to intervene or implement Individual #23's training plan for thumb-sucking as written.

b. Individual #23's list of "B" goals included the following that were not noted to be implemented during observations conducted on 5/18/06, 5/19/06, and 5/20/06 for a cumulative 6 hours 20 minutes: increase participation in treatment activities, come to the table for group activities, and participate in an appropriate retirement activity schedule.

For example, during the above noted observations on 5/19/06 and 5/20/06, staff were not noted to attempt to increase his participation in treatment activities, encourage him to come to the table for group activities, or encourage his participation in an appropriate retirement activity.

6. Individual #24's PCP, dated 1/25/06, documented a 58 year old male diagnosed with severe mental retardation, seizure disorder, and spastic quadriplegia. He used a wheelchair for ambulation and mobility.

a. Individual #24's training plan, titled Mealtime Training, dated 4/11/06, stated he fed himself with staff assistance and "this skill has declined in recent years." Under the section titled Instructions to Staff, it stated staff were to assist him to scoop his food and bring the food to within

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five inches of his mouth. Individual #24 was to bring the spoon of food the last five inches to his mouth.

During an observation on 5/19/06 from 4:00 - 6:10 p.m., Individual #24 was transferred from his wheelchair to the dining table. Staff used a built-up angled spoon and fed him his dinner meal.

Individual #24's Mealtime Training plan was not implemented as written. During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated staff were not to feed Individual #24.

b. Individual #24's list of "B" goals included the following that were not noted to be implemented during observations conducted on 5/18/06, 5/19/06, and 5/20/06 for a cumulative 6 hours 20 minutes: participate in exercise, join a small group, make choices, or participate in independent table activities.

For example, during an observation on 5/19/06 from 4:00 - 6:10 p.m., Individual #24 was noted to propel himself around the outside patio area and in the unit for an hour. Staff were not noted to encourage him to join a small group, make choices, or participate in independent table activities.

During an observation on 5/20/06 from 1:30 - 2:30 p.m., Individual #24 went to his bedroom at 1:57 p.m. and closed the door. A staff person walked into and out of his bedroom at 2:18 p.m. Individual #24 remained in his room with the door closed when the observation ended. Staff were not noted to encourage him to participate in

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W 249	Continued From page 146 exercise, join a small group, make choices, or participate in independent table activities. 7. Individual #13's BSP, updated 6/16/05, stated he was a 16 year old male diagnosed with impulse control disorder (not otherwise specified), paraphilias, and mild to moderate mental retardation. His BSP stated he engaged in physical assaults, sexual misconduct, invasion of space, and grooming related to sexual misconduct. The plan further stated that due to his level of aggression he "has warranted intense supervision and strict programming." The plan instructed staff to have Individual #13 "within total line of sight when he is awake" and "staff will not help other staff with duties that require them to give up the line of sight." During an observation on, on 5/15/06 at 7:10 p.m., Individual #13 was observed cleaning counter-tops in the kitchen and dining areas. At 7:30 p.m., a staff was asked what level of supervision Individual #13 required. The staff supervising Individual #13 stated line of sight was being maintained because Individual #13 was working with chemicals. At 7:35 p.m., the staff answered a phone call at the desk, leaving Individual #13 unsupervised in the kitchen with cleaning chemicals. At 7:38 p.m., the staff took a piece of paper to the desk, leaving Individual #13 unloading the dishwasher and unsupervised in the kitchen with cleaning chemicals. At 7:40 p.m., the staff took a soda can and piece of paper to the desk, leaving Individual #13 unsupervised in the kitchen with cleaning chemicals. On all three occasions, the position of the staff person in relation to the position of Individual #13 prevented line of sight supervision.	W 249		

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W 249	Continued From page 147 The facility failed to ensure Individual #13's BSP was consistently implemented in relation to his line of sight status. 8. Individual #9's PCP, dated 3/30/06, documented a 33 year old male with diagnoses of inappropriate sexual activity including pedophilia, impulse control disorder NOS, PTSD, and mild mental retardation. During an observation on 5/18/06 at 2:10 p.m., Individual #9 was observed sitting in front of the soda machine writing. He then walked to the storage area and returned with several sodas and placed them in the soda machine. Staff were observed in the area and asked if they were working with Individual #9. The staff stated he was and when asked what Individual #9's programs were, the staff stated he was from another unit but he was told to stay in the general area and "to hang out" as the two individuals working {#9 and #78} were "pretty independent". Individual #9's PCP included the following objective: "{Individual #9} will accurately write target words related to his Canteen job on 10 consecutive data probes by 5/07. Step C: Diet Dr. Pepper, Ice Tea, Orange, Diet Lime by briefly referring to a printed model not more than 2 times. Step D: Diet Dr. Pepper, Ice Tea, Orange, Diet Lime without referring to a printed model (no cue). Step E: Dr. Pepper, Sprite, Dasani Water, Rootbeer by briefly referring to a printed model no more than 2 times.	W 249		

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W 249	Continued From page 148 Step F: Dr. Pepper, Sprite, Dasani Water, Rootbeer without referring to a printed model (no cue). Step G: Diet Rootbeer, Minute Maid, Coke 2 (C-2), Diet 7-up by briefly referring to a printed model no more than 2 times. Step H: Diet Rootbeer, Minute Maid, Coke 2 (C-2), Diet 7-up without referring to a printed model (no cue)." The section titled Instructions to Staff, stated the program was to be run on the living area during Adult Ed scenario, and whenever functional writing opportunities occurred during daily activities. During interview with the QMRP on 6/14/06 at 1:00 p.m., the QMRP stated the program was scheduled to be run in the evening, however, it could have been implemented as an opportunity training. She further stated when staff were borrowed from another unit, it was difficult to ensure programs were implemented.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure active treatment schedules were in place to provide a	W 250		

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W 250	Continued From page 149 range of options and sufficient direction to staff for 9 of 18 individuals (Individuals #6, 20 - 25, 59, and 60) whose active treatment schedules were reviewed. This resulted in schedules which were not individualized and the potential for inconsistencies between established objectives and activity choices offered to individuals. The findings include: 1. Individual #6, 20 - 25, 59, and 60s' active treatment schedules were reviewed. It was noted the schedules included similar and identical activities/programs, as follows: a. Active treatment schedules, titled Combined Activity Schedule, undated, showed the following for Individuals #6, 20 - 25, 59, and 60: 6:00 - 8:00 a.m.: Morning routine and domestic skills. 7:30 - 8:00 a.m.: Meal set-up. 8:00 - 9:45 a.m.: Breakfast time. 9:00 - 10:15 a.m.: Meal clean-up and grooming. 10:15 a.m. - 12:00 p.m.: Work and retirement activities: Vocational group (Individuals #6, 20, 21, 25 and 60): - Monday through Friday: Work, snack. - Saturday: Church music, med building, church chapel, snack. - Sunday: Practice clinics, snack. Retirement group (Individuals #22, 23, 24, and 59): - Monday: Shop community, sensory/craft, snack.	W 250		

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- Tuesday: Cook, snack.
- Wednesday: Pool campus, sensory/craft, snack.
- Thursday: Snack.
- Friday: Canteen.
- Saturday: Church music, med building, church chapel, snack.
- Sunday: Practice clinics, snack.

11:45 a.m. - 12:00 p.m.: Lunch set up.

12:00 - 1:30 p.m.: Lunch time.

1:00 - 1:30 p.m.: Lunch clean-up and grooming.

1:00 - 2:00 p.m.: Room maintenance and appearance check.

The schedule was not individualized; it did not contain individuals' formal and informal training plans, individuals' likes and dislikes, instructions to staff on what to do if an individual refused to participate, or what to do if they finished the task before its allotted time.

b. Active treatment schedules, titled Activity Schedule Pine 2 Swing Shift, revised 4/06, showed the following for Individuals #6, 20 - 25, 59, and 60:

2:00 - 2:30 p.m.: Greetings and personal appearance. Med pass for Individuals #22 and 59.

2:30 - 4:00 p.m.: Monday - Friday: Vocational activities for Individuals #6, 20, 21, 25 and 60 and Saturday and Sunday: Personal laundry, table games, relaxation, campus walk or gym time, snack. The following schedule was noted for

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W 250	Continued From page 151 Individuals #22, 23, 24, and 59, who were retired: - Monday: Pool for Individuals #22, 24 and 59, snack on unit for Individuals #22, 23, 24 and 59, room maintenance for Individual #23. - Tuesday: Canteen purchase training for Individuals #22, 23, 24, 59, and 60 (after work). - Wednesday: Sensory room or activities in gym for Individuals #22, 23, 24, and 59, snack. - Thursday: Canteen purchase training for Individuals #22, 23, 24, and 59. - Friday: Sensory room or activities in gym for Individuals #22, 23, 24, and 59, snack. - Saturday and Sunday: Personal laundry, table games, relaxation, campus walk or gym time, snack. 4:00 - 4:30 p.m.: Monday - Friday: Medical building break room/snack for Individuals #6, 20, 21, and 25. For Individual #60, it stated "return home." Snack and appearance check for Individuals #22, 23, 24, and 59 except Tuesday when they were to go to the lobby for music with the Chaplin. Saturday and Sunday: "densense" (desensitization) activities or table activities for all individuals. 4:30 - 5:00 p.m.: Monday - Friday: "densense" (desensitization) activities or table activities. Saturday and Sunday: Personal appearance and room maintenance. 5:00 - 5:30 p.m.: Meal set-up and hand washing. 5:30 - 6:30 p.m.: Meal and socialization activities. 6:30 - 7:00 p.m.: Med pass and appearance check. Thursday: Walk to canteen for Individuals #6, 20, 21, 25, and 60.	W 250		

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W 250	Continued From page 152 7:00 - 8:30 p.m.: - Monday: Community outing for Individuals #6, 22, 23, 24, and 59. Leisure choice: table games, relaxation, or desense for Individuals #20, 21, 25, and 60. Snack at 7:30 p.m. - Tuesday: Community outing for Individuals #20, 21, 22, 25, 59, and 60. Leisure choice: music appreciation, tables games, relaxation, or desense for Individuals #6, 23, and 24. Snack at 7:30 p.m. - Wednesday: Community outing for Individuals #6, 22, 23, 24, and 59. Leisure choice: music appreciation, tables games, relaxation, or desense for Individuals #20, 21, 22, 25, 59, and 60. Snack at 7:30 p.m. - Thursday: Canteen for Individuals #6, 20, 21, 25, and 60 and walk home. Leisure choice: table games, relaxation, or desense for Individuals #22, 23, 24, and 59. Snack at 7:30 p.m. - Friday: Pool for Individuals #6, 20, 22, 24, and 25. Leisure choice: music appreciation, tables games, relaxation, or desense for Individuals #21, 23, 59, and 60. Snack at 7:30 p.m. - Saturday: Community outing for Individuals #20, 21, 22, 25, 59, and 60. Leisure choice: Lawrence Welk, desense, table games for Individuals #6, 23, and 24. Snack at 7:30 p.m. - Sunday: Mini-theatre for Individuals #6, 20, 21, 25, and 60. Leisure choice: table games, relaxation, or desense for Individuals #22, 23, 24, and 59. Snack at 7:30 p.m. 8:30 - 10:00 p.m.: Baths and/or evening grooming, relaxation activities. The schedule was not individualized; it did not contain individuals' formal and informal training plans, individuals' likes and dislikes, instructions	W 250		

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to staff on what to do if an individual refused to participate, or what to do if they finished the task before its allotted time.

When asked about the active treatment schedules, the QMRP stated during an interview, on 6/15/06 from 9:00 a.m. - 1:00 p.m., they used a scenario book which contained individuals' formal and informal training plans.

The Scenario Book, undated, showed the following scenarios and their purpose:

- The first 17 pages were individuals' lists of goals and objectives taken from their PCPs.

- Pre-Meal: To provide opportunities for hand washing, setting table, choice making, and communication.

- Meal-Time: To provide a calm atmosphere and promote interaction and cooperation. Attached to the Meal-time scenario were individuals' mealtime programs.

- Post-Meal Clean-Up: To provide opportunities for face and hand washing and domestic chores "to the extent that client abilities and sanitation allow."

- Snack-Time: To provide opportunities to set up, clean up, and choose healthy snacks.

- Canteen: To provide opportunity for interaction, cooperation, socialization, and money management.

- Morning and Evening Medications: To learn the

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importance of taking medications, wait to be called to the medication administration area, self administration of medication, and hand washing.

- Encourage Physical Awareness: To encourage individuals to point to named body parts.

- Walking Scenario: To provide exercise and teach traffic safety.

- Evening Activities: To gain skills to improve ability to relax, gain leisure skills, participate in group activities, socialization, and participate in exercise and range of motion activities. Possible activities included "massage or exercise/stretching/range of motion," gardening, outside leisure/lawn games (i.e., swings, ramp bowling, horse shoes, lawn darts, ring toss), and Karaoke and table games.

- Encouraging Imitation Skills: To encourage individuals to imitate simple actions.

- Transporting: To learn and practice functional mobility and rules of safety.

- Movie Time: To provide a leisure activity.

- Desensitization to Medical Procedures at Home: To train individuals to allow medical personnel to touch, to follow instructions, and to relax. Attached to the scenario was a list of individuals' desensitization training priorities.

- Desensitization to Medical Procedures Clinic Activity: To train individuals to relax, to sit/lay on an exam table, or sit in a dental chair. Attached to the scenario was a list of individuals'

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W 250	Continued From page 155 desensitization training priorities. - Room Maintenance: To assist individuals to clean and organize their bedrooms. The scenarios were not individualized, they did not contain specific instructions or directions to staff on what and whose programs (formal and informal) were to be implemented, they did not contain individuals' likes and dislikes, they did not contain specific instructions or directions to staff on what to do if an individual refused to participate in the scenario, or what to do if they finished the scenario before its allotted time. When asked who developed the active treatment schedules/scenario book, the QMRP stated during an interview, on 6/15/06 from 9:00 a.m. - 1:00 p.m., the DDSs (shift supervisors). The facility failed to ensure active treatment schedules were individualized and contained sufficient information to direct the intensity of the daily work of the staff.	W 250		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure data related to maladaptive behaviors was consistently	W 252		

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and accurately collected as specified in the behavior support programs and reflective of actual individual performance for 4 of 21 individuals (Individuals #16 - 18 and 20) whose behavior support plans and data were reviewed. Failure to document data consistently impeded the IDT's ability to evaluate the effectiveness of programmatic techniques. The findings include:

1. Individual #20's PCP, dated 1/11/06, documented a 49 year old male diagnosed with severe mental retardation, anxiety disorder (not otherwise specified), right side hemiparesis secondary to infantile stroke, seizure disorder, Raynaud's Syndrome, severe migraine headaches, and osteoporosis.

His PCP stated he was legally blind with complete retinal detachment in his right eye, and his left eye and his right little finger were absent because of his self injurious behavior (SIB). Individual #20's BSP, titled Managing Symptoms of Anxiety, updated 4/4/06, included the following definitions for SIB:

- Bites to Self: "An incident of bites to self occurs when [Individual #20] successfully or unsuccessfully attempts to bite his wrist, arm, or hand area. This behavior is counted regardless of whether it produces injury."

- Head Hit: "An incident of head hitting occurs when [Individual #20] slaps, hits, scratches, or punches at his face or head area. This behavior also includes hitting head against objects. This behavior is counted regardless of whether it produces injury. This behavior is used to assess program and medications effectiveness as it

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poses the most significant protection from harm issue, is the behavior that is most closely correlated with his mental health and is a reaction to both internal and external stressors."

Under the section titled Interventions for self injurious behaviors for arm biting and head hitting, it stated staff were to redirect or distract him. If he continued with greater intensity, staff were to say "[Individual #20] put your arms down" and block his arms. If he did not respond, staff were to say and tactile sign "[Individual #20] stop." If a mat was available, staff were to put it near him and say "[Individual #20] a mat is in front of you." The plan stated he would independently use the mat to lie down and calm himself.

Under the section titled Data Collection, it stated staff were to record each incident of assault, bites to self, and head hits on the Behavior Reporting Form (BRF). The corresponding Behavior Reporting Form (BRF) contained five columns and each column was titled as follows:
- Time
- Location & Activity
- Antecedent
- Behavior
- Consequence

Under the column titled Antecedent, it stated "What happened before the threat, physical assault or SIB behavior? What non-restrictive measures were used prior to the problem? What activity was the person redirected to?"

Under the column titled Behavior, it stated "Describe the behavior in detail: i.e. hit kick, scratched, bite. Describe severity."

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Under the column titled Consequence, it stated "What did staff do following the behavior? Restarted activities?"

Individual #20's BRFs, dated 2/06 - 5/21/06, showed entries that did not comply with the above noted directions. Examples include, but are not limited to, the following:

2/1/06 at 10:28 a.m.:
- Location & Activity: "TV Room."
- Antecedent: "Attempted to change shoes."
- Behavior: "Bite x 2, head hitting x 5." The severity of the behavior was not documented.
- Consequence: "Took [Individual #20] to room. [Individual #20] chose to use matt [sic] program x 3." It was unclear what "chose to use matt [sic] program x 3" meant, whether or not the intervention was effective, what Individual #20's response was to the intervention, and whether or not activities were restarted.

2/3/06 at 3:10 p.m.:
- Antecedent: "[Individual #20] was finishing toileting. Staff attempted to help him get dressed."
- Behavior: "Hitting head against wall, biting self on hands and upper arm, attempted to bite staff." Corresponding checked-marked data showed he bit himself 8 times, hit his head 3 times, and hit his head against the wall 2 times. The severity of the behavior was not documented.
- Consequence: "Redirected [Individual #20] to chair, started to bite himself again, asked [Individual #20] if he would like to go to his mat. He did for 15 min." It was unclear what "redirected to chair" meant (i.e., verbally,

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physically, or both), whether or not staff intervened when he "started to bite himself again", how Individual #20 responded to the intervention, and whether or not activities were restarted.

2/15/06 at 7:50 p.m.:
- Location & Activity: "Med room."
- Antecedent: "Was in med. room getting med. for his eye's [sic]. Once the nurse put meds. on clients eye he began to hitting [sic] his head."
- Behavior: "Was getting meds in med. room. Nurse was putting eye meds. on [Individual #20's] eye then he became upset and was slapping self, was told to stop hitting self, then bitten [sic] left hand. The number of times he hit his head and the severity of the hits and the bite were not documented.
- Consequence: "Removed him from med room." It was unclear what "removed" meant, whether or not the intervention was effective, how Individual #20 responded to the intervention, and whether or not activities were restarted.

3/29/06 at 4:00 p.m.:
- Location & Activity: "Transporting from Voc."
- Antecedent: "Angry at cut on finger. Nurse applied bandaid, became more angry."
- Behavior: "Bite to arm x 4, hits to head x 11." The severity of the bites and hits was not documented.
- Consequence: "Verbally tried to calm, physically held head from mouth, took [Individual #20] to his room, used mat." It was unclear what "verbally tried to calm" meant, at what point staff intervened during the "hits to head x 11", how Individual #20 responded to the intervention, and whether or not activities were restarted.

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3/1/06 at 7:25 (a.m./p.m. not indicated):
- Location & Activity: "Table games."
- Antecedent: "Playing Yatzee - eye bothering him."
- Behavior: "Slapping left side of head." Corresponding check-marked data showed hit his head four times. The severity of the hits was not documented.
- Consequence: "Gave him a chance to lay on his matt [sic]." It was unclear what "gave him a chance" meant, at what point staff intervened during the behavior, how Individual #20 responded to the intervention, and whether or not activities were restarted.

3/12/06 at 6:45 p.m.:
- Location & Activity: "[Individual #20's] bathroom."
- Antecedent: "[Individual #20] was preparing for MT, put on a shirt and it ripped. [Individual #20] became mad and took off shirt then became more angry."
- Behavior: "[Individual #20] bit self x 1, slapped head x 5, hit chest x 2." The severity of the bite and the hits were not documented.
- Consequence: "Used mat to relax, was on mat for 10 min." It was unclear how Individual #20 responded to the intervention and whether or not activities were restarted.

3/29/06 at 4:15 p.m.:
- Location & Activity: "Bedroom."
- Antecedent: "[Individual #20] was mad at the pain."
- Behavior: "Bit self on hand x 2, hit head on floor x 1 (blood)." The severity of the bites and the location of the head hit were not documented.

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- Consequence: "Held [Individual #20's] head, asked to calm. [Individual #20] calmed and got into chair to relax." It was unclear how long it took Individual #20 to calm and whether or not activities were restarted.

4/5/06 at 9:30 p.m.:
- Location & Activity: "[Individual #20's] room, shower."
- Antecedent: "[Individual #20] was toileting and when talking/asking him if he wanted to shower he started having behaviors."
- Behavior: "Bites self on right wrist, slaps left side of head." Corresponding check-marked data showed he bit himself 2 times and hit/slapped his head 3 times. The severity of the bites and hits was not documented.
- Consequence: "Verbal redirection." It was unclear what "verbal redirection" meant, whether or not staff intervened during the behavior, how Individual #20 responded to the intervention, and whether or not activities were restarted.

4/7/06 at 6:55 a.m. and at 7:15 a.m.:
- Location & Activity: "[Individual #20's] room, morn. routine."
- Antecedent: "[Individual #20] was cued that it was time to get up for the day."
- Behavior: "Bites to self, right arm." The severity and number of bites were not documented.
- Consequence: "Verbal redirection and left him alone to "wake-up." It was unclear if the intervention was effective, how Individual #20 responded to the intervention, if and how long it took Individual #20 to calm, and whether or not activities were restarted.

4/16/06 at 9:55 p.m.:

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W 252	Continued From page 162 - Location & Activity: "Bedroom." - Antecedent: "Put lotion on rash on back." - Behavior: "Bit his right wrist." Corresponding check-marked data showed he bit himself 2 times. The severity of bites was not documented. - Consequence: "Told him he was fine and back off, left him alone." It was unclear if the intervention was effective, how Individual #20 responded to the intervention, if and how long it took Individual #20 to calm, and whether or not activities were restarted. 4/19/06 at 3:55 p.m.: - Location & Activity: There was no entry recorded. - Antecedent: There was no entry recorded. Corresponding check-marked data showed "Told to do something" was checked. It was unclear what "Told to do something" meant. - Behavior: There was no entry recorded. Corresponding check-marked data showed "Bites to self" and "Hits/slaps head" were checked. The severity of bites and hits was not documented. - Consequence: There was no entry recorded. Corresponding check-marked data showed "verbal redirection" was checked. It was unclear what "verbal redirection" meant, whether or not it was effective, how Individual #20 responded to the intervention, and whether or not activities were restarted. 4/27/06 at 8:58 p.m..: - Location & Activity: "TV room." - Antecedent: "Relaxing in the TV room, peer outside TV room began yelling." - Behavior: "[Individual #20] hit chest hard several times, hit head 4 xs, used mat to calm in room." Corresponding check-marked data showed he bit	W 252		

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himself one time, hit his head four times, and hit his chest hard three times. The severity of the bite and the hits to his head were not documented.
- Consequence: "Tried to verbally calm and redirect to room. Calmed and complied to get ready for bed." It was unclear what "Tried to verbally calm and redirect to room" meant and how long it took Individual #20 to calm.

5/5/06 at 7:05 p.m.:
- Location & Activity: "In client's bathroom."
- Antecedent: "Client was receiving meds in bathroom, the nurse had just finished applying medication to client's eyes."
- Behavior: "Client slapped himself on left side of head." Corresponding check-marked data showed he hit his head four times. The severity of the slaps was not documented.
- Consequence: "Staff verbally redirected client. Client calmed down." It was unclear what "verbally redirected" meant, how long it took Individual #20 to calm, and whether or not activities were restarted.

5/21/06 at 9:30 p.m.:
- Location & Activity: "Client's bathroom, shower."
- Antecedent: "Client was in bathroom taking a shower."
- Behavior: "Client slapped head three times." The severity of the slaps was not documented.
- Consequence: "Asked client to stop, gave client space." It was unclear what "gave client space" meant, if the intervention was effective, how Individual #20 responded to the intervention, how long it took Individual #20 to calm, and whether or not activities were restarted.

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5/21/06 at 3:40 a.m.:
- Location & Activity: "Bedroom."
- Antecedent: "Did bed check was wet - verbal skill bathroom and bed."
- Behavior: "Bit self with hand in head, also hit head on wall - bit wrist area - pull own hair."
Corresponding check-marked data showed he bit himself three times and hit his head four times. The severity of the bites and hits was not documented.
- Consequence: "Directed back to bed and left room." It was unclear what "directed" meant, if the intervention was effective, how Individual #20 responded to the intervention, and how long it took Individual #20 to calm.

In sum, the data did not consistently and specifically describe the behaviors Individual #20 engaged in (no entry recorded; "Bites to self" and "Hits/slaps head" were checked), the number of times it occurred ("Bites to self, right arm"), the severity of the behavior, and the program steps that were followed ("Directed back to bed and left room). In addition, the data collected did not identify or describe how Individual #20 responded to staffs' interventions.

When asked who reviewed BRF data, the QMRP stated during an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., it was recently changed to the DDSs (shift supervisors) reviewing them at the end of each shift and the Clinician also reviewed them, but she was not sure how often.

The practice of not recording comprehensive information related to Individual #20's maladaptive behaviors would not allow his interdisciplinary team to ascertain the

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effectiveness of the behavioral interventions being utilized. The facility failed to ensure complete, accurate data was collected such that it was reflective of Individual #20's actual individual performance and as specified in his behavior support program.

2. Individual #17's BSP, updated 5/18/05, stated he was a 13 year old male. His BSP included objectives for assaults, leaving without permission, obsessive episodes, and destruction of property. The data only section of the BSP stated the "Conners ADHD scale was to be administered every three months by the Clinician. (The Conners measures impulsivity, hyperactivity and ability to focus.)" However, the completed scales could not be found in Individual #17's record. When asked about the scales, the Clinician stated during an interview on 6/19/06 at 12:30 p.m., he had completed the scales since becoming the unit's Clinician but he did not know about the scales prior to his coming to the facility.

Individual #17's Conners ADHD scales prior to 3/23/06 could not be found. The facility failed to ensure data was taken as specified in Individual #17's plan.

3. Individual #16's BSP, updated 5/17/06, stated he was a 15 year old male. His BSP included objectives for assault, suicide threats, destruction of property, self injurious behavior, and leaving without permission. His BSP included an objective to "have a T-score of 55 or less on the Conner's' [sic] Rating Scale (ADHD) subcategory tested quarterly for 6 months..." His BSP also included a medication plan which documented the following related to Strattera:

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- Strattera 40 mg twice a day for ADHD as evidenced by impulsivity, attention problems and assaults. Criteria for increasing the medication was set at 30 or more assaults per month and/or a T-score of 60 or more per month on the ADHD subscale of the Connors Rating Scale. Criteria for decrease was set as 15 or less assaults per month for 6 consecutive months and/or T-score of 55 or less per month on the ADHD subscale of the Connors Rating Scale.

The data collection section of his plan stated the Connor Rating Scale "will be administered every three months" and the Depression Observation Checklist will be administered monthly..."

When asked about the scales, the Clinician stated during an interview on 6/19/06 at 12:30 p.m., he had completed the scales since becoming the unit's Clinician but he did not know about the scales prior to his coming to the facility. Individual #17's Conners ADHD scales prior to 3/23/06 could not be found and his Depression Observation Checklists prior to 4/28/06 could not be found.

4. Individual #18's PCP, dated 5/11/06, stated he was a 21 year old non-verbal male diagnosed with severe mental retardation, possible autism, seizure disorder by history, and multiple scars secondary to self injurious behavior. Individual #18's PCP contained a "Behavior Support Program," dated 8/30/05, to instruct staff as to how to intervene when he engaged in the self-injurious behavior of hitting his head.

His Behavioral Reporting Forms were reviewed

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for the period 2/1/06 - 6/12/06.
The Behavioral Reporting Forms specified that staff were to have also recorded the following information on the form - (a) antecedent information (i.e., what happened before the self-injurious behavior), (b) a description of "the behavior in detail," along with a description of "severity," and (c) what staff did following the behavior/how the person reacted. None of that information had been recorded. In addition, it was not specified what protective measures staff had utilized to keep Individual #18 from harming himself. Examples include:

On 2/11/06, Individual #18 hit himself in the head at 7:45 a.m., 1:00 p.m., 1:15 p.m., and 1:30 p.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits Individual #18 had inflicted to himself, nor for how long each occurrence of the behavior had continued. A form titled "Supplemental Investigation Form" said he was "offered time alone with soothing music" and "offered a bath." There was no corresponding data recorded/attached to reflect whether or not Individual #18 had taken part in either of those activities.

On 2/19/06, Individual #18 hit himself in the head at 8:02 a.m., 8:17 a.m., 8:30 a.m., 11:43 a.m., and 1:15 p.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. A form titled "Supplemental Investigation Form" said he was

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"offered other activities, food, beverages, and a bath." There was no corresponding data recorded/attached to reflect which, if any, of those activities Individual #18 subsequently participated in. The check marks show redirection to activities was unsuccessful four of the five times.

On 3/5/06, Individual #18 hit himself in the head at 8:50 a.m. One mark had been recorded for the aforementioned time period. Information recorded on the form stated that he engaged in "high intensity hits to R temple." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. A form titled "Supplemental Investigation Form" said staff "attempted to offer him a drink, applesauce and music." There was no corresponding data recorded/attached to reflect which, if any, of those activities Individual #18 subsequently participated in.

On 3/23/06, Individual #18 hit himself in the head at 8:55 a.m. Initially 5 marks had been recorded for the aforementioned time period. The 5 marks had been circled and an error notation made, along with a single mark. Information recorded on the form stated that he engaged in "high intensity hits to R temple." It also said that he had been "offered several things to have, he didn't want anything." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had actually inflicted to himself, nor for how long the behavior had continued.

On 4/1/06, Individual #18 hit himself in the head

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W 252	Continued From page 169 at 7:45 a.m., 8:00 a.m., 8:15 a.m., 8:30 a.m., and 8:45 a.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The form did not specify how staff had protected Individual #18 from harming himself. On 4/16/06, Individual #18 hit himself in the head at 7:32 a.m. and 7:47 a.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The Behavioral Reporting Form stated staff provided "non direct redirection, offered coffee, music and a walk, also offered Tylenol." There was no corresponding data recorded/attached to reflect which, if any, of those things Individual #18 subsequently took/engaged in. On 5/1/06, Individual #18 hit himself in the head at 12:00 p.m. and 12:15 p.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The Behavioral Reporting Form stated staff "took (him) on a walk to try and redirect, also offered drinks, and a variety for a snack, he continued to hit self on R temple." It was not specified what protective measures staff had used to keep Individual #18 from harming	W 252		

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W 252	Continued From page 170 himself. On 5/24/06, Individual #18 hit himself in the head at 11:30 a.m. and 1:45 p.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The behavior reporting forms did not consistently contained clear, comprehensive information as how many times Individual #18 had hit himself in the head, for how long, what had occurred prior to him engaging in the self-injurious behavior, provide specifics as to what staff had done to protect him from continuing to harm himself if initial cues/redirection were unsuccessful, and/or that the information recorded was correct. Individual #18's QMRP and Clinician were interviewed on 5/22/06, from 11:10 a.m. - 11:55 a.m. and from 1:35 p.m. - 2:20 p.m. They were asked if the single marks recorded on the Behavioral Reporting Forms were to denote single intense hits Individual #18 made to his head. They stated they were recording episodes versus each individual hit, and that the number could vary from 1 on up. They also confirmed at that time that staff had not been recording additional narrative information as to (a) antecedent information (i.e., what happened before the self-injurious behavior), (b) a description of "the behavior in detail," along with a description of "severity," and (c) what staff did following the behavior/how the person reacted. In addition, it was not specified what protective	W 252		

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measures staff had utilized to keep Individual #18 from harming himself.

On 6/1/06, Individual #18 hit himself in the head at 7:45 a.m. One mark had been recorded for the time period. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The Behavioral Reporting Form specified that staff were to have also recorded the following information on the form - (a) antecedent information (i.e., what happened before the self-injurious behavior), (b) a description of "the behavior in detail," along with a description of "severity," and (c) what staff did following the behavior/how the person reacted. None of that information had been recorded. In addition, it was not specified what, protective measures staff had utilized to keep Individual #18 from harming himself.

On 6/11/06, Individual #18 hit himself in the head 3 times at 8:05 a.m., as noted by 3 slash marks made under the section to record hard hits to his head. From the data recorded on the Behavioral Reporting Form, it could not be determined how long the behavior had actually continued. In the narrative section of the form staff recorded the hits were "low" intensity. The QMRP stated during interview on 6/12/06 from 11:25 p.m. - 11:35 p.m., that staff should have not recorded the 3 slash marks denoting hard hits, because as the narrative section stated, the hits were low intensity. The QMRP said that summarized monthly data reflecting the number of hard hits Individual #18's inflicted to his head would have automatically been counted based on the slash

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W 252	Continued From page 172 marks alone. She further explained that staff assigned that duty would not have read through the narrative data. Such an error would skew the accuracy of summarized data reflecting his progress and/or regression with reaching the established objective of reducing the behavior. The facility failed to ensure comprehensive data was taken as specified in individuals' PCPs and/or that it was accurate.	W 252		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals' objectives were revised as appropriate for 2 of 16 individuals (Individuals #14 and #15) whose behavior summary data was reviewed. This resulted in individuals continuing to receive formal training on objectives they had successfully completed. The findings include: 1. Individual #14's BSP, dated 3/29/06, stated he was a 14 year old male. His BSP included objectives for assaults, self induced vomiting, destruction of property, and self harm. His objective for Destruction of Property stated he	W 255		

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would "have 5 or less Destruction of property (DOP) [sic] per month for 6 consecutive months by 2/07." His monthly summary data from 11/05 - 4/06 documented the following episodes of DOP:

11/05: 1
12/05: 1
1/06: 1
2/06: 1
3/06: 3
4/06: 0

When asked if the objective had been revised, the Clinician stated during an interview on 6/19/06 at 12:30 p.m., he was in the process of revising all of the behavior plans for the individuals on the unit.

2. Individual #15's BSP, dated 1/27/06, stated he was a 14 year old male. His BSP included objectives for assaults, DOP, LWOP, and bizarre speech.

a. His objective for assaults stated he would "reduce assaults to 10 per month for 3 consecutive months by 1/07." His summary data for assaults listed the following:

01/06: 9
02/06: 3
03/06: 5
04/06: 10

b. His objective for DOP stated he would "reduce incidents of DOP to 10 per month for 3 consecutive months by 1/07." His summary data for DOP listed the following:

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W 255	Continued From page 174 01/06: 4 02/06: 7 03/06: 10 04/06: 3 c. Individual #15's objective for Bizarre Speech stated he would "reduce incidents of Bizarre Speech to 5 for 6 consecutive months by 1/07." His summary data for Bizarre Speech, dated 1/06-4/06, listed the following: 01/06: 4 02/06: 0 03/06: 2 04/06: 0 Previous summary data for Bizarre Speech, dated 09/05-12/05, listed the following: 9/05: 5 10/05: 3 11/05: 3 12/05: 2 Individual #15 met criteria for Bizarre Speech four months prior to the revision of the plan and continued to be met for four months following the revision of the plan. When asked if the objectives had been revised, the Clinician stated during an interview on 6/19/06 at 12:30 p.m., he was in the process of revising all of the behavior plans for the individuals on the unit. The facility failed to assure Individual #15's BSP was revised when he had successfully completed objectives identified in his plan.	W 255		

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W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure PCPs were revised to accurately reflect and respond to individuals' current needs and functional changes for 9 of 21 individuals (Individuals #11 - #19) whose BSPs were reviewed. That failure resulted in PCPs which were not reflective of their current status. The findings include: 1. Individual #17's BSP, updated 5/18/05, stated he was a 13 year old male. His BSP included objectives for assaults, leaving without permission, obsessive episodes, and destruction of property. The data only section of the BSP included invasion of personal space and sexual misconduct. a. His BSP stated the "program was updated on 5/18/05 to add positive interventions/replacement behaviors to help provide alternatives to [Individual #17's] obsessing/fixating. This program has also been updated to include sexual misconduct since [Individual #17] has been starting to display behaviors of grabbing at people's genitals, pulling his pants down and asking people to do inappropriate actions. The team has agreed to address this behavior at its beginning stages before it develops into potentially more serious behavior."	W 260		

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When asked about a specific objective related to Individual #17's sexual misconduct, the QMRP stated during an interview on 6/15/06 at 8:56 a.m., he had only one incident. Staff decided to track for a pattern, but no pattern was found so it was not being looked at at this time. The information in Individual #17's BSP (grabbing at people's genitals, pulling his pants down and asking people to do inappropriate actions) was not consistent with the treatment team's description of the one documented incident.

b. His BSP further stated the team was requesting "Lexapro to replace Prozac to decrease [Individual #17's] obsessive symptoms." However, review of Individual #17 PDR notes reflected Lexapro had replaced Prozac in 3/05. The BSP was not revised to reflect his current medications when revisions were made in 5/05 or when his PCP was updated in 3/06.

2. Individual #13's BSP, updated 6/16/05, stated he was a 16 year old male diagnosed with impulse control disorder (not otherwise specified) paraphilias, and mild to moderate mental retardation. His BSP included objectives for physical assaults, sexual misconduct, invasion of space, and grooming related to sexual misconduct. He was re-admitted to the facility on 3/23/05.

Individual #13's BSP stated, "Fecal Manipulation: Determine if [Individual #13's] behavior requires immediate protection from harm (i.e., head banging)." During interview, on 6/15/06 at 3:05 p.m., the QMRP was asked if Individual #13 displayed head banging as a behavior. The

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W 260	Continued From page 177 QMRP stated there was no data to support that statement. The Acting Administrative Director stated it looked as if the information was cut and pasted from a different document. The facility failed to ensure the individuals' BSP's were updated as needed. 3. Refer to W214 as it relates to the facility's failure to ensure updated adequate assessment information was documented and incorporated into the individuals' BSPs. 4. Refer to W255 as it relates to the facility's failure to ensure individuals' objectives were revised as appropriate when individuals met the criteria established in their objectives. 5. Refer to W312 as it relates to the facility's failure to ensure individuals' medication plans were revised as appropriate to reflect the individuals' current status.	W 260		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the human rights committee was provided with sufficient	W 262		

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review information prior to obtaining approval for restrictive techniques for 4 of 17 individuals (Individuals #13 - #16) reviewed who had restrictive interventions in place. This resulted in a potential for individuals being subjected to restrictive interventions unnecessarily. The findings include:

1. On 5/15/06, the Clinical Director provided a memo related to Pine Group 1. The memo stated the following had occurred:

8/05: The QMRP was on leave until she resigned on 11/2/05 and other professional staff were assisting to perform the QMRP responsibilities until a new QMRP was hired on 1/27/06.

11/05: The adolescents were combined into one group. "The move of course did cause increased problems."

12/2/05: The Pine Group 1 Clinician resigned. The Clinical Supervisor was assigned as the interim Clinician until a new Clinician could be hired on 3/6/06.

Additionally, the individuals residing on the unit changed as some were discharged and some were admitted (i.e. Individuals #5 and #12 were admitted on 10/21/05 and 2/3/06 respectively), increasing the number of maladaptive behaviors and restraints on the unit.

A "BRC, HRC and Team Member Review and Approval of Proposed Intervention" form, dated 2/22/06, was attached to Individual #15's BSP, dated 1/27/06. The form stated the team had "considered the therapeutic value of this program

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and the possible risks to [Individual #15] and agree that the proposed interventions are the least intrusive interventions necessary to ensure protection of [Individual #15] and others."

The BSP stated Individual #15 was a 14 year old male diagnosed with bipolar disorder, hypomania vs. mixed with psychosis, attention deficit hyperactive disorder (ADHD) combined type, oppositional defiant disorder by history, learning disability not currently specified, nocturnal enuresis, and probably mild mental retardation. The BSP included objectives for assaults, DOP, LWOP, and bizarre speech. The "Functional Assessment" section of the plan stated he was "very sensitive to noise and chaos which can result in his becoming nervous, frustrated or anxious which leads to yelling at others and sometimes escalating into targeted behaviors like physical assault and LWOP."

The assessment did not include information related to continuing changes in his peer group, the changes in his treatment team members, or what impacts those changes were having on Individual #15's behavior.

Without updated assessment information in his BSP, reflecting environmental factors which potentially impacted his maladaptive behavior, the facility would not be able to ensure the HRC was provided with sufficient information necessary to make fully informed recommendations and/or give approvals for Individual #15's restrictive behavior interventions.

2. Individual #14's BSP, dated 3/29/06, stated he was a 14 year old male. His BSP included